Washington State Health Care Authority
Medicaid

Medicaid Provider Billing Workshop

Name of Presenter: Jasmine Douglas, Matt Ashton, Gary Monroe, Ed Hicks - Provider Relations Unit
Date: July 19, 2012

Washington State Health Care Authority
Medicaid

Provider Training

Medicaid Overview

- What is Medical Assistance?
- Eligibility Programs
- Fee for Service
- Manage Care Organizations
- Healthy Options
- Basic Health
- Life of a Claim

ProviderOne

- Direct Data Entry (DDE) Claims
- Medicare and Medicare Advantage Crossover Claims
- Commercial Secondary Claims
- Saving Claims
- Build and Use a Claim Template
- Manage ProviderOne users
- Enroll a New Rendering Provider
- Provider File Maintenance

Billing Processes

- Check Patient Eligibility
- Claim Status Inquiry
- System Authorization Information
- Obtain the Remittance Advice
- Adjust or Void a Paid Claim
- Resubmit a Denied Claim
- Appeals
- Authorization Requests

Various Other Billing

Family
Ambulance
Newborn
Spend Down

POS
Family Planning
Swing Bed
Ambulance

Billing the Client
HIPAA
Transactions

Reference Materials

Web Pages
Webinars
Billing Instructions

Discovery Log
Contacts

What is Medical Assistance?

- Washington's Medical Assistance program provides healthcare coverage for low-income residents.
- The Health Care Authority operates Medicaid and coordinates other health and recovery programs.
  - ✓ State's Mental Health programs
  - ✓ Chemical Dependency and prevention treatment
  - ✓ Family Planning
- Clients receive healthcare services through:
  - ✓ A Managed Care Organization
  - ✓ Fee-For-Service

Key Terms and Acronyms

BSP
Benefits Service Package

RHC
Rural Health Center

RSN
Regional Support Network

FQHC
Federally Qualified Health Center

PCCM
Primary Care Case Management

CSO
Community Services Office

Fee for Service
The term used when a client is able to get care from doctors and other medical providers who will accept the client service card.

Managed Care
A prepaid comprehensive system of medical and health care services provided through a designated health care plan that contracts with Medicaid

Spenddown
An expense or portion of an expense which has been determined by the Agency to be client's liability

Eligibility Programs

Benefit Service Packages (BSP)

CNP

Categorically Needy Program

This program has the largest scope of care.

MNP

Medically Needy Program

This program covers many medical services.

TCFPO

Take Charge-Family Planning Service Only

This program is for both women and men. Covers family planning services.

FPSO

Family Planning Services

This program is for women.

DL

Disability Lifeline

This program covers most of the basic services.

ADATSA

Alcoholism and Drug Addiction Treatment and Support Act

This program covers most of the basic services.

For a complete listing of BSP visit:
http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide/Appendix_E.pdf

Covered Services

Service/Program	Categorically Needy		Medically Needy	Disability Lifeline		Take Charge Family Planning
	CN	CHIP	MN	DL	ADATSA	TC /FP
Adult day health	Y	N	N	N	N	N
Ambulance (ground/air)	Y	Y	Y	Y	Y	N
Ambulatory surgery center	Y	Y	Y	R[1]	R[1]	N[1]
Blood/Blood administration	Y	Y	Y	Y	Y	N
Childbirth education	Y	Y	N	N	N	N
Chiropractic services for children	Y	Y	Y	N	N	N
Dental services, non-emergent (routine)	N[9]	Y	N[9]	N	N	N
Emergency dental services	Y	Y	Y	Y	Y	N
Crowns/Dentures	N[9]	Y[3]	N[9]	N	N	N
Detoxification	Y	Y	Y	R	R	N
Diabetes education	Y	Y	Y	Y	Y	N
Early periodic screening diagnosis & treatment (EPSDT) program	Y	Y	Y	N	N	N
Family planning services	Y	Y	Y	Y	Y	Y
Hearing services (audiology & exams)	Y	Y	Y	N	N	N
Hearing devices	N[9]	N[9]	N[9]	N	N	N
HIV/AIDS Case Management	Y	Y	Y	N	N	N
Home health services	Y	Y	Y	Y	Y	N
Home infusion therapy parenteral nutrition	Y	Y	Y	Y	Y	N
Hospice/Pediatric palliative care services	Y	Y	Y	N	N	N
Hospital services – inpatient/outpatient	Y	Y	Y	Y	Y	N1
Intermediate care facility/services for the mentally retarded (IMR)	Y	Y	Y	Y	Y	N
Kidney center/end-stage renal disease	Y	Y	Y	Y	Y	N
Maternity care & delivery services	Y	Y	Y	N	N	N
Maternity support/infant case management	Y	Y	N	N	N	N

Covered Services (cont)

Service/Program	Categorically Needy		Medically Needy	Disability Lifeline		Take Charge Family Planning
	CN	CHIP	MN	DL	ADATSA	TC/FP
Wheelchairs, durable medical equipment	Y	Y	Y	Y	Y	N
Nondurable medical equipment (MSE)	Y	Y	Y	Y	Y	N
Enteral nutrition services	Y	Y	Y	Y	Y	N
Medical nutrition therapy	Y[4]	Y[4]	Y[4]	R[4]	R[4]	N
Mental health services (general)	Y	Y	Y	R[5]	N	N
Inpatient hospital care	Y	Y	Y	Y	Y	N
Outpatient hospital care	Y	Y	Y	R	R	N
Mental health services – children	Y	Y	Y	N	N	N
Nursing facility services	Y	Y	Y	Y	N	N
Organ transplants	Y	Y	Y	Y	Y	N
Out-of-state services (excludes border cities)	Y	Y	Y	N[6]	N[6]	N
Oxygen/respiratory services	Y	Y	Y	Y	Y	N
Personal care services	R	R	R	N	N	N
Physician-related services	Y	Y	Y	Y	Y	R
Prenatal Diagnosis Genetic counseling	Y	Y	Y	N	N	N
Prescription drugs*	Y	Y	Y	Y	Y	R
Private duty nursing for children	Y	Y	Y	N	N	N
Prosthetic/Orthotic devices	Y	Y	Y	Y	Y	N
Psychological Evaluations	Y	Y	Y	N[7]	N[7]	N
School medical services	Y	N	Y	N	N	N
Smoking cessation	Y	Y	Y	Y	N	N
Substance abuse services (chemical dependency)	Y	Y	Y	Y[8]	Y[8]	N
Outpatient Therapy – occupational, physical, speech	N[9]	Y	N[9]	N	N	N
Vision care exams	Y	Y	Y	Y	Y	N
Vision hardware (lenses, frames, contacts)	R[9]	Y	R[9]	N	N	N

- You can find this booklet , 22-315 at http://hrsa.dshs.wa.gov/mpapublications.shtml

Accessing ProviderOne

- Before logging into ProviderOne:
  - ✓ Make sure you are using Microsoft Internet Explorer version 6.0 and above.
  - ✓ You turn **OFF** the Pop Up Blocker.
  - ✓ You are using a PC (MACs are not supported by ProviderOne).

Eligibility

How Do I Obtain Eligibility In ProviderOne

- Select the proper user profile

1

Welcome
to the
Medicaid Management Information System

Note: There are three different profiles that can be used for checking client eligibility in ProviderOne

- **EXT Provider Eligibility Checker**
- **EXT Provider Eligibility Checker-Claims Submitter**
- **EXT Provider Super User**

Select a profile to use during this session: EXT Provider Eligibility Checker * Go

EXT Provider Eligibility Checker-Claims Submitter
EXT Provider Super User

Online Services:

Claims Hide/Max

- Claim Inquiry
- Claim Adjustment/Void
- On-line Claims Entry
- On-line Batch Claims Submission (837)
- Resubmit Denied/Voided Claim
- Retrieve Saved Claims
- Manage Templates
- Create Claims from Saved Templates
- Manage Batch Claim Submission

2

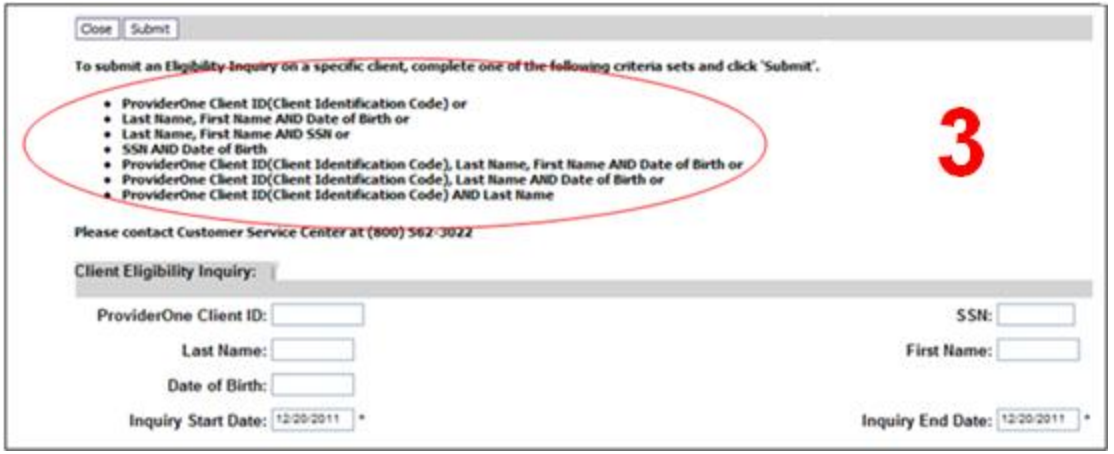
Client Hide/Max

- ~~Client Limit Inquiry~~
- Benefit Inquiry

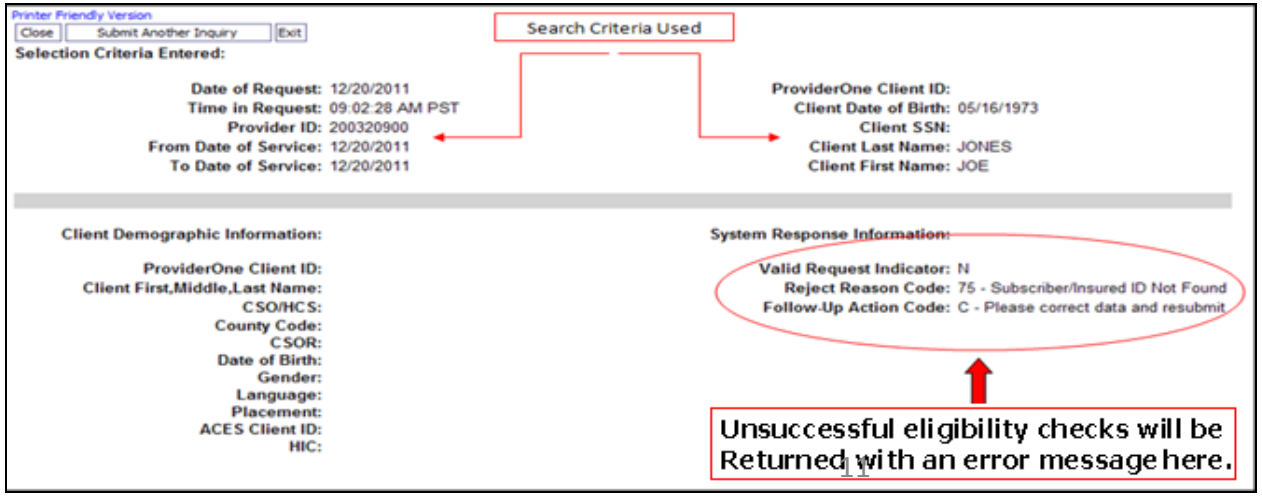
Select "Benefit Inquiry" under the "Client" section of the Provider Portal

How Do I Obtain Eligibility In ProviderOne

- Use one of the search criteria listed along with the dates of service to verify eligibility.



- An unsuccessful check would look like this:



✓ Client is not eligible for your search dates; or

✓ Check your keying!

Washington State Health Care Authority

Successful Eligibility Check

Printer Friendly Version

Close | Submit Another Inquiry | Exit

Selection Criteria Entered:

Search Criteria Used

4

Date of Request: 12/20/2011
Time in Request: 10:11:16 AM PST
Provider ID: 110320900
From Date of Service: 12/20/2011
To Date of Service: 12/20/2011

ProviderOne Client ID: 600212788WA
Client Date of Birth:
Client SSN:
Client Last Name:
Client First Name:

Client Demographic Information:

ProviderOne Client ID: 600212788WA
Client First,Middle,Last Name:
CSO/HCS: 133-OAK HARBOR/ISLAND COUNTY HCS
County Code: 015-Island
CSOR: 015-OAK HARBOR CSO
Date of Birth: 06/28/1951
Gender: Female
Language: ENG-English
Placement:
ACES Client ID: 602411160
HIC:

System Response Information:

Valid Request Indicator:
Reject Reason Code:
Follow-Up Action Code:

Basic client information returned including the Client ID, Gender, and Date of Birth

Note: The eligibility information can be printed out using the "**Printer Friendly Version**" link located in the upper left corner.

Successful Eligibility Checks

- After scrolling down the page the first entry is the "**Client Eligibility Spans**" which shows:
  - ✓ The eligibility program (CNP, MNP, etc).
  - ✓ The date span for coverage.

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1147	CNP	02/01/2011	12/31/2999	L21			

<< Prev Viewing Page 1 Next >> 1 Go Page Count Save To XLS

Note: Clicking on the "**CNP**" hyperlink will display the "Benefit Service Package" which is a list of covered services for the client.

"Managed Care Information"

Healthy Options Managed Care plans will be listed

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	MHC Healthy Options	105010201	(800) 869-7165		06/01/2010	12/31/2999
HM: Health Maintenance Organization	MC: Capitated	Spokane County Regional Support Network	105021301	(800) 273-5864		06/01/2010	12/31/2999

<< Prev Viewing Page 1 Next >> 1 Go Page Count Save To XLS

The local Regional Support Network for Medicaid client's mental health services will be displayed in this section.

PCP clinic name populated here when available for RHC's, FQHC's, and PCCM's.

Successful Eligibility Checks

"Medicare Eligibility Information"

Medicare Eligibility Information

Service Type Code	Insurance Type Code	Eligibility Start Date	Eligibility End Date
30: Health Benefit Plan Coverage	MB: Medicare Part B	03/01/1980	12/31/2999
30: Health Benefit Plan Coverage	MA: Medicare Part A	02/01/1979	12/31/2999

<< Prev | Viewing Page 1 | Next >> | 1 | Go | Page Count | SaveToXLS

- If client has Medicare Part A or Part B this information will be shown with the Medicare eligibility effective dates of service.
- If the client has enrolled in a Medicare Advantage Plan (Part C), if reported, it is listed in the **"Coordination of Benefits Information"** section.

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	RXAMERICA (800) 429-6686	S5644		Med Part D			01/01/2008	12/31/2011
30: Health Benefit Plan Coverage	C1: Commercial	STERLING LIFE INSURANCE COMPANY (360) 647-9080	H5006		Med Part C			03/01/2006	12/31/2010

<< Prev | Viewing Page 1 | Next >> | 1 | Go | Page Count | SaveToXLS

Successful Eligibility Checks

"Coordination of Benefits Information"

- Will display phone number and any policy or group numbers on file with WA Medicaid for the commercial plans listed.
- For DDE claims the Carrier Code (Ins. ID) is found here.

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	KAISER PERMANENTE MED CARE (800) 813-2000	HM10		13482256			09/01/2010	12/31/2999

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

- There are two ways to update any COB information in ProviderOne:
  - Provider or client can contact COB 1-800-562-3022 extension 16134
  - Submit claim with EOB information which can be used to update ProviderOne.

Successful Eligibility Checks

"Restricted Client Information"

- Client's may be restricted to specific Hospitals, PCP's, and Pharmacies for care. A referral is required from the PCP for specialized care.

Restricted Client Information

Assignment Type	Provider Name	Provider Phone Number	Period Start Date	Period End Date
Hospital	MULTICARE HEALTH SYSTEM		01/05/2010	12/31/2999
Pharmacy	WALGREEN CO		01/01/2010	12/31/2999
Primary Care Physician	SEA-MAR COMMUNITY HEALTH CENTER		01/01/2010	12/31/2999
Primary Care Physician	DITTMER, STEPHANIE		01/01/2010	12/31/2999

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

Successful Eligibility Checks

"Hospice Information"

- Client's may be enrolled in a Hospice agency for care:

Hospice Information

Hospice agency	Hospice Address	Hospice Phone	Hospice Contact	Start date	End date
102071700	PROVIDENCE HOSPICE OF SEAT, 425 PONTIUS AVE N STE 300, SEATTLE, WA 98109-5312			03/15/2011	03/18/2011

<< Prev | Viewing Page 1 | Next >> | 1 | Go | Page Count | SaveToXLS

Note: If a client is assigned to a Hospice agency, bill the Hospice agency for any care related to the client's terminal illness. WA Medicaid has paid a monthly payment to the agency to cover these services.

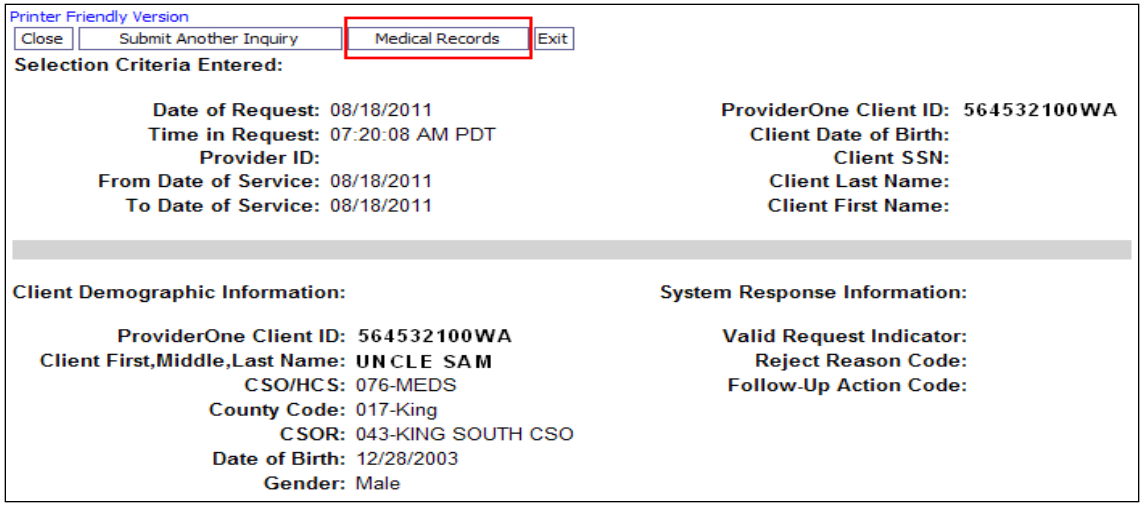
Note: If service is not related to the client's terminal illness, bill these services to WA Medicaid with a note "SCI=K" or with a statement "Not related to terminal illness".

- The last section of the eligibility check lists the source of the eligibility data.

Successful Eligibility Checks

"Foster Care Information"

- Foster Care Client's Medical Records History is available.
  - ✓ There is an extra button at the top of the eligibility screen.



  - ✓ Click the button to see:
    - Pharmacy services claims.
    - Medical services claims (includes dental).
    - Hospital services claims.
- See the Billing and Resource Guide for complete details. Web address is on the last slide.

Successful Eligibility Checks

"Foster Care Information"

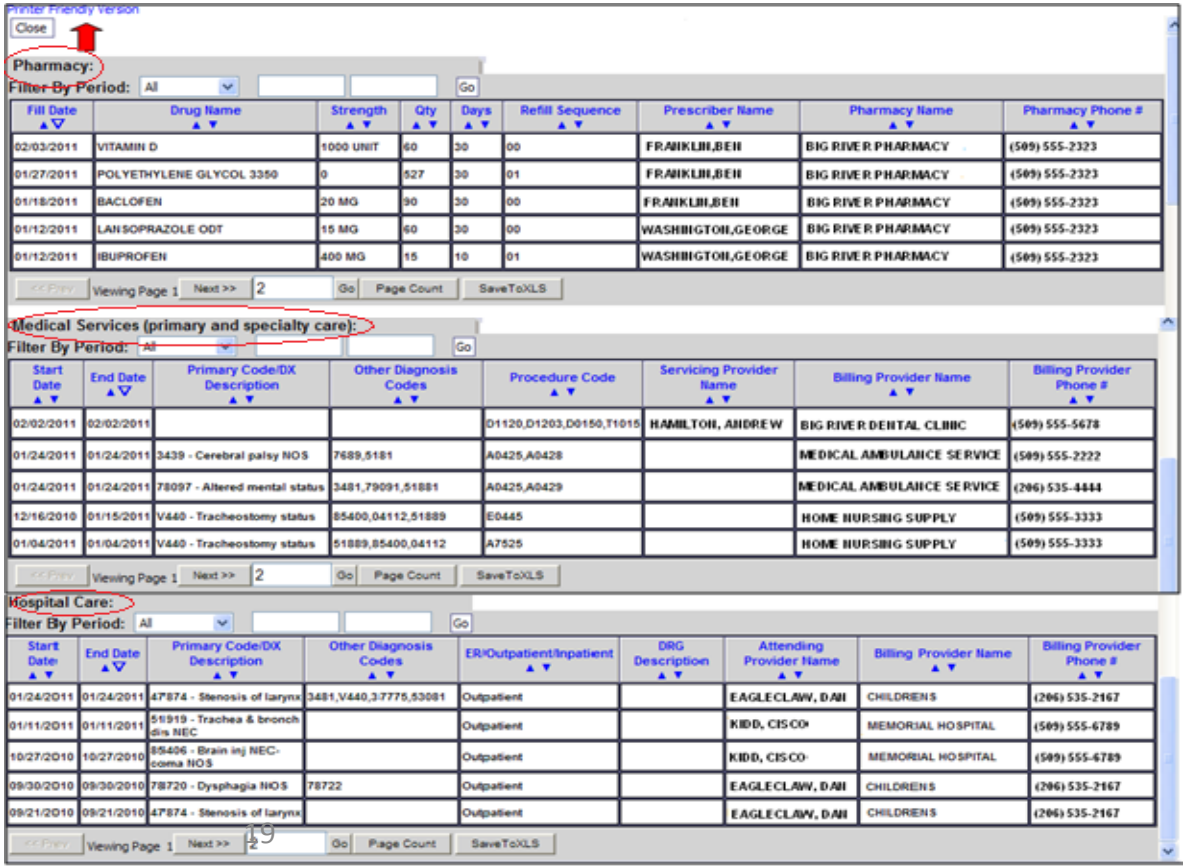
➢ Foster Care Client's Medical Records History shows claims paid by ProviderOne. Each section looks like:

- ✓ If any field is empty there is no data for it.
- ✓ Sort by using the "diamonds" under each column name: 

- ✓ Search by using the "Filter by Period" boxes.
- ✓ If there is more pages of data use the "Next" or "Previous" buttons:

- ✓ If there is no data for the section it will display:

No Records Found !



Helpful Links Related to Client Eligibility

For the following Fact Sheets, use the hyperlink listed below:

- Client Services Card Fact Sheet
- Client Eligibility Verification Fact Sheet
- Interactive Voice Response (IVR) Fact Sheet
- Magnetic Card Reader Fact Sheet

http://hrsa.dshs.wa.gov/providerone/Providers/Fact%20Sheets/FactSheets.htm

For the E-Learning Webinar on how to check eligibility in ProviderOne, use the hyperlink listed below:

http://hrsa.dshs.wa.gov/providerone/EEligibility.htm

For the Self-Paced Online Tutorial on how to check eligibility, use the hyperlink listed below:

http://hrsa.dshs.wa.gov/providerone/ProviderTutorials.htm

For the ProviderOne Billing and Resource Guide, use the hyperlink listed below:

http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html

Life of a Claim

Paper Claims

Electronic, DDE Claims

PROVIDERONE
- Assigns a TCN
- Scanned information is verified
- E-Claims, DDE information verified

Optical Scanner
- Work Scan Errors

History and Claims Analysis

Suspended Claims
- Authorization
- Eligibility
- Coordination of Benefits
- Program Limitations

Final Claim Disposition

RA , 835 Generated

Warrants printed

EFT deposits

Manage Users

Manage Users

- How to get access into the system.
- How to set up a user.
- How to lock out and unlock a user.
- How to reset a password.
- How to end a user.

How to get access into the system

- Review the ProviderOne Security Manual at http://hrsa.dshs.wa.gov/providerone/documentation/Provider%20System%20User%20Manual/H.%20Maintaining%20ProviderOne%20User%20Accounts.pdf
- New provider and don't have the "form" Email ProviderOne Security at provideronesecurity@hca.wa.gov In the subject line enter "request for Provider Supplemental Information Request Form"

How to get access into the system

- The Provider Supplemental Information Request form is for a newly enrolled Facility, Clinic, or Individual Provider.
- Fill it out and fax it in to 360-586-0702 for ProviderOne access.

Washington State Health Care Authority

IMMEDIATE ACTION REQUIRED

ProviderOne ID:

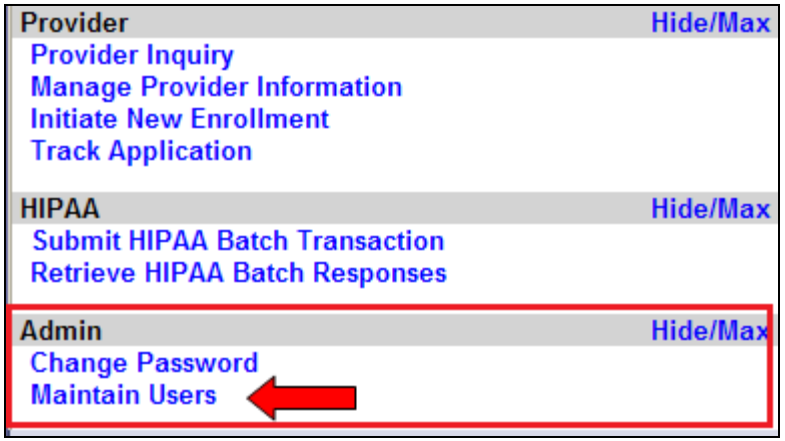
PROVIDER SUPPLEMENTAL INFORMATION REQUEST

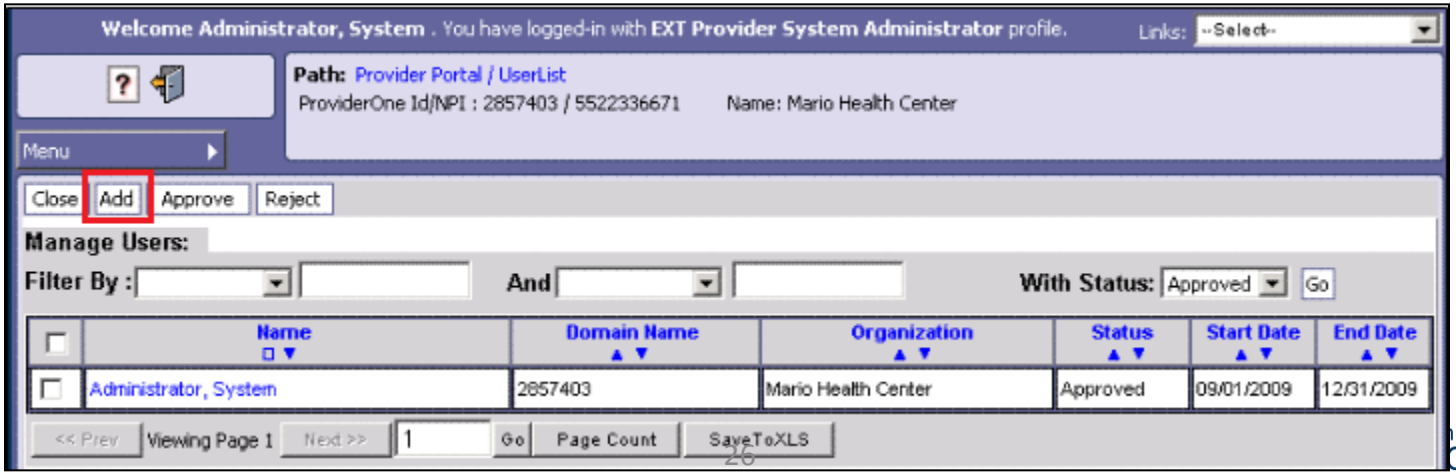
The Health Care Authority has transitioned to its new claims payment system called ProviderOne. Completion of this form is necessary to designate your Security Administrator who will be issued a Username and temporary password to access ProviderOne. Your Security Administrator is responsible for overseeing access to ProviderOne for your staff: setting up additional users and user profiles in your assigned Domain (ProviderOne ID).

PROVIDERONE SECURITY ADMINISTRATION	
Name of Security Administrator (First, Last, Middle Initial)	Physical Address (Street) (City) (State) (Zip)
Security Administrator's Date of Birth	Business Name
Security Administrator's Email Address	National Provider Identifier (NPI)
Security Administrator's Phone Number	Federal Tax ID (FEIN)
Providers must respond within seven (7) days of receiving this request. Fax this form back to HRSA/IT Security at (360) 586-0702, scan and email to provideronesecurity@hca.wa.gov or mail to Provider Enrollment, PO Box 45512, Olympia, WA 98504-5512.	

How to set up a user

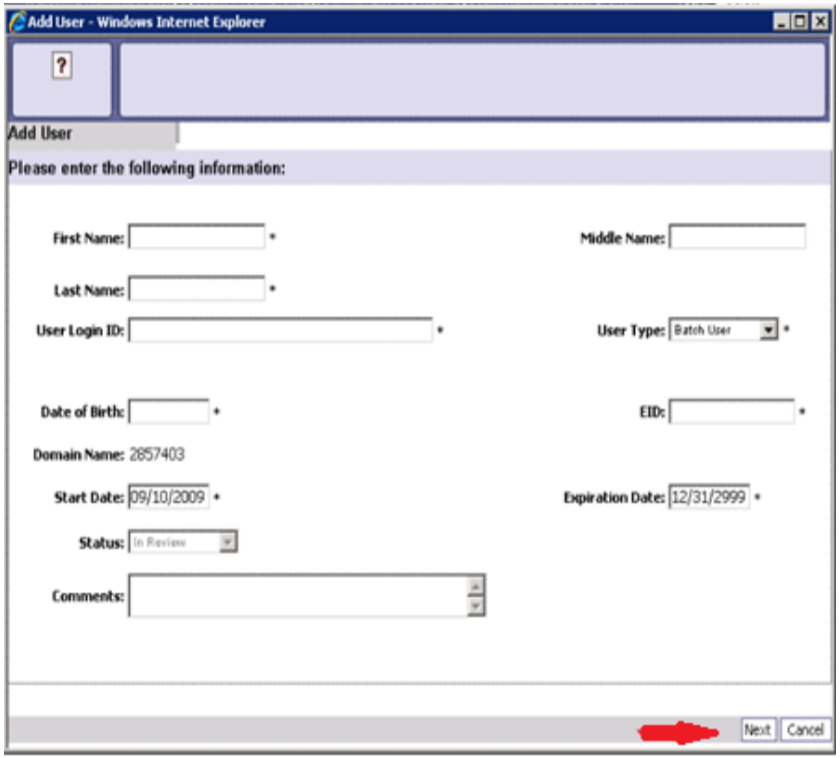
- Log in with the **"System Administrator"** Profile
- Click on **Maintain Users**
- The system now displays the **"User List"** screen
- Click on the **"Add"** button

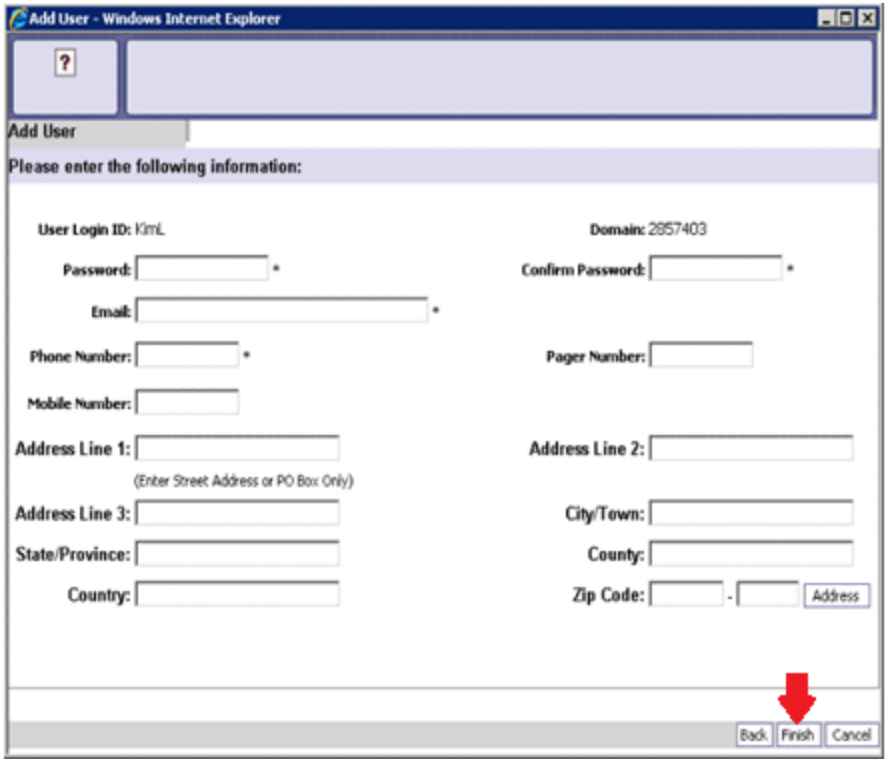




How to set up a user

- Adding a user

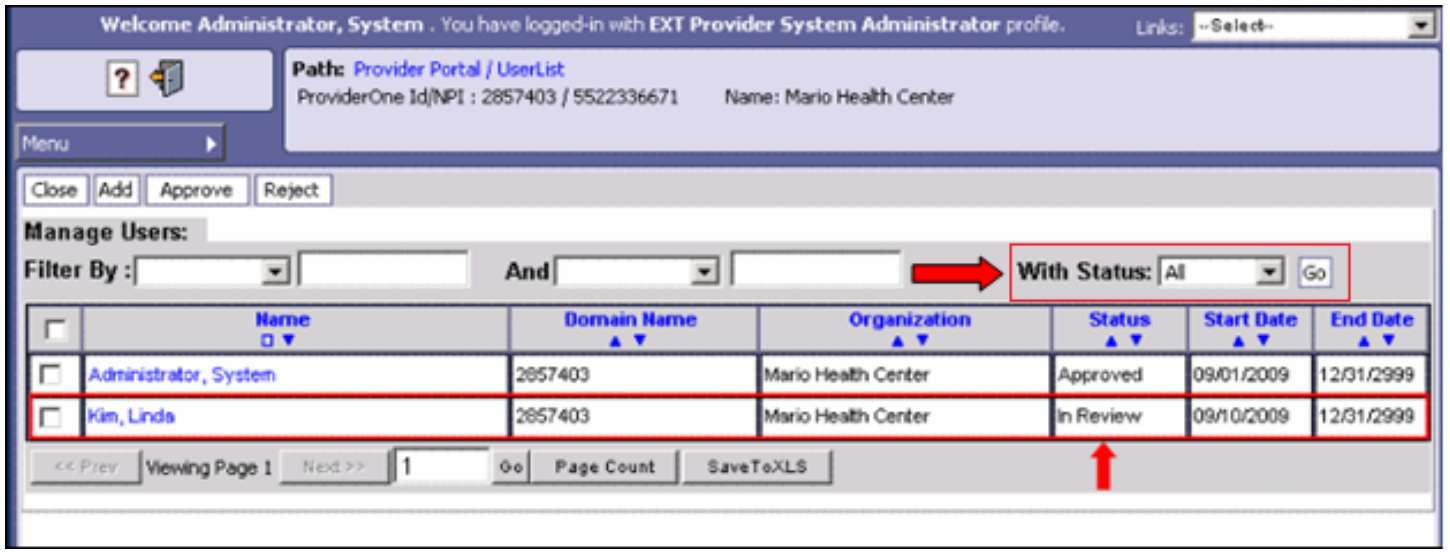




- Fill in all required boxes that have an asterisk *
- The address is not needed here

How to set up a user

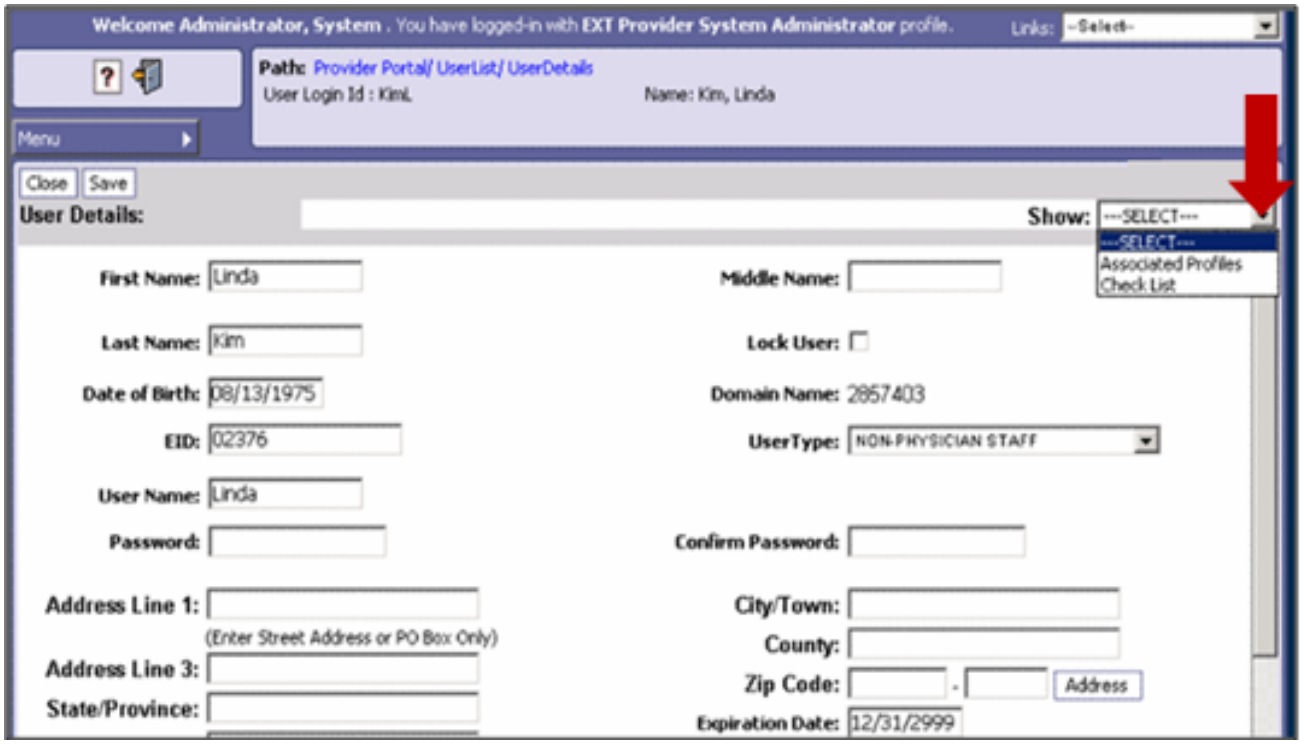
- Adding a User



- To display the new user
  - ✓ In the **"With Status"** box display **"All"**, then click Go
  - ✓ The user's name is displayed with **"In Review"** status.
  - ✓ Click the box left of the user's name, then click the Approve button. User will then be approved.

How to set up a user

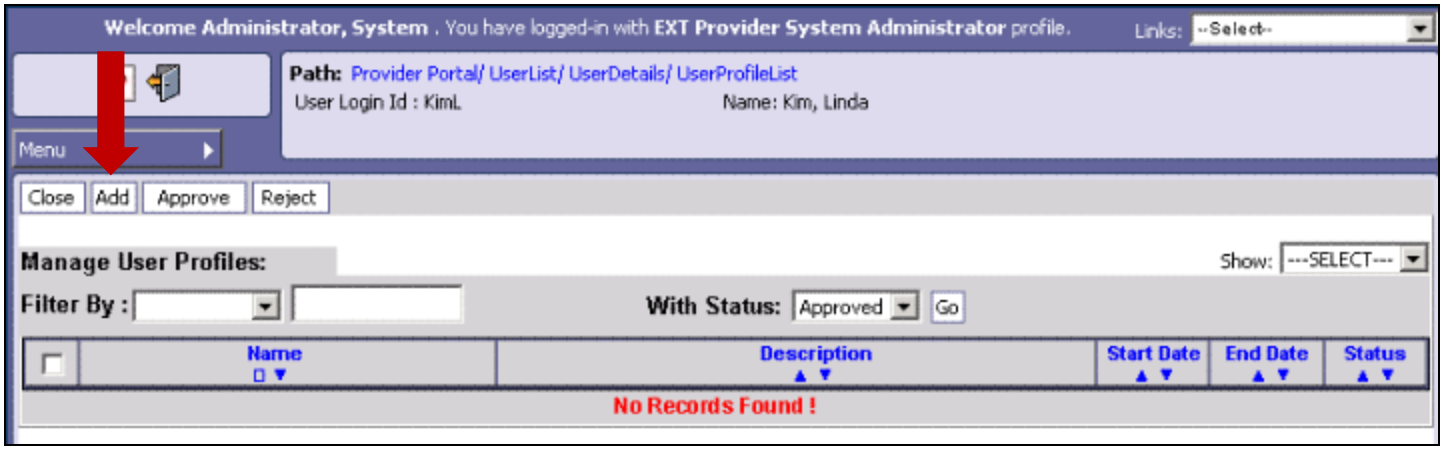
- Adding Profiles
  - ✓ Get here by clicking on the users name on the previous screen.



  - ✓ On the **"Show"** menu click on Associated Profiles.

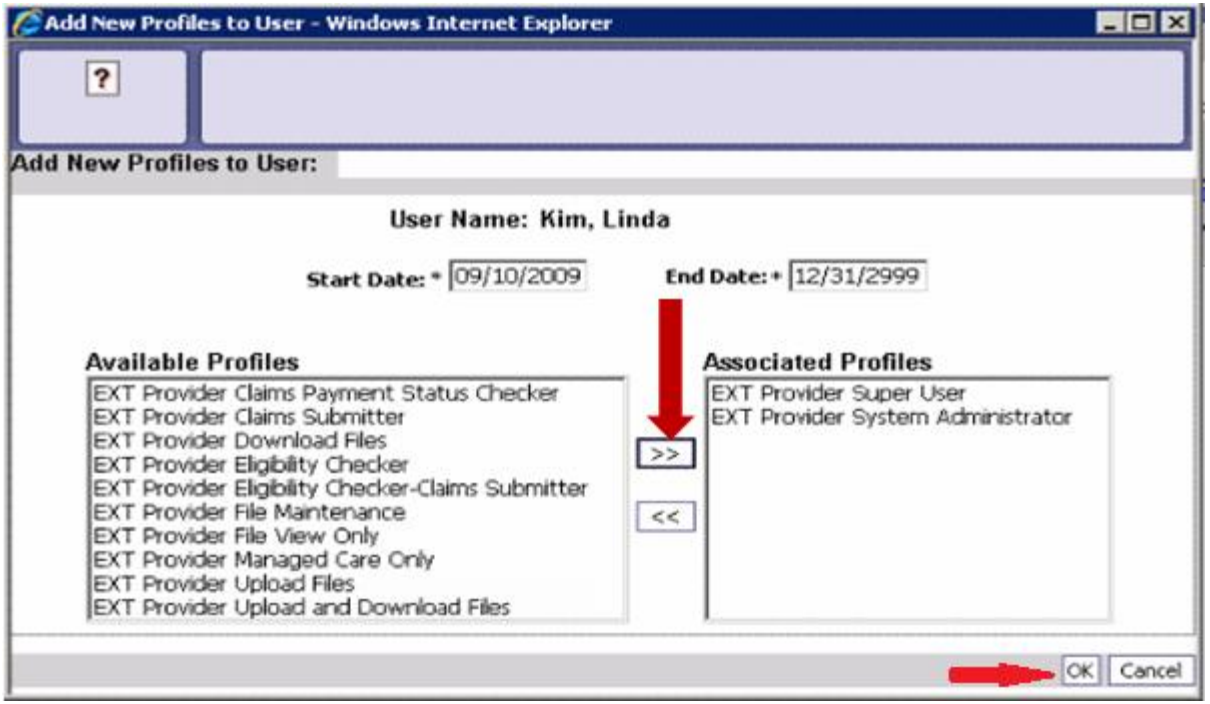
How to set up a user

- Adding Profiles
  - ✓ Click on the **"Add"** button to select profiles



How to set up a user

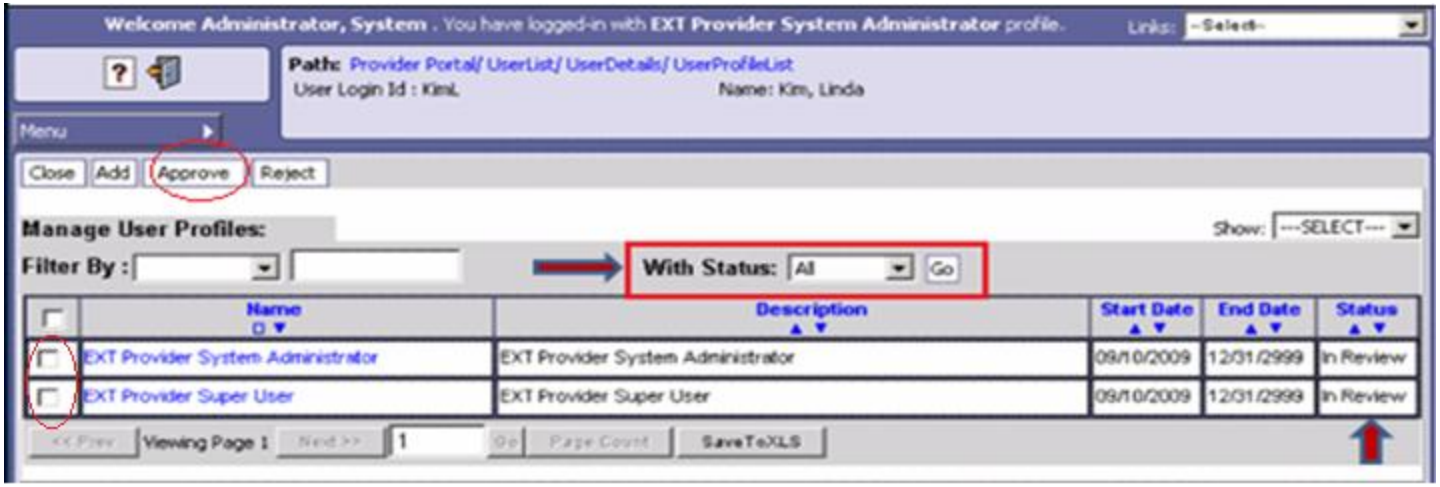
- Adding Profiles



- ✓ Highlight Available Profile(s) desired and click double arrow and move to "Associated Profiles" box then click the **"OK"** button.

How to set up a user

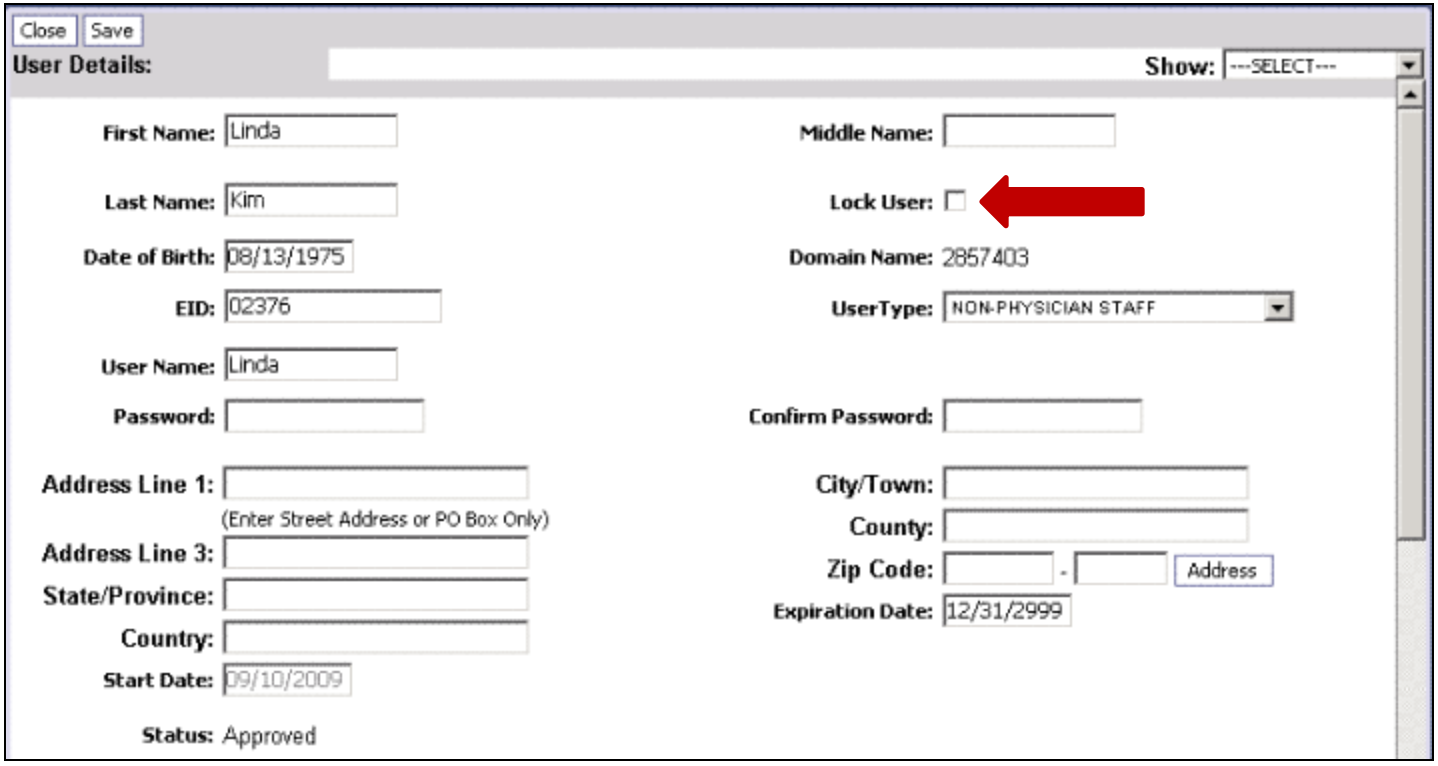
- Adding Profiles



- To Display the new profiles
  - ✓ In the "**With Status**" box display "**All**", then click Go
  - ✓ The profiles are displayed with **"In Review"** status.
  - ✓ Click the box to the left of the profile name, then click the **"Approve"** button. Profiles will then be approved.

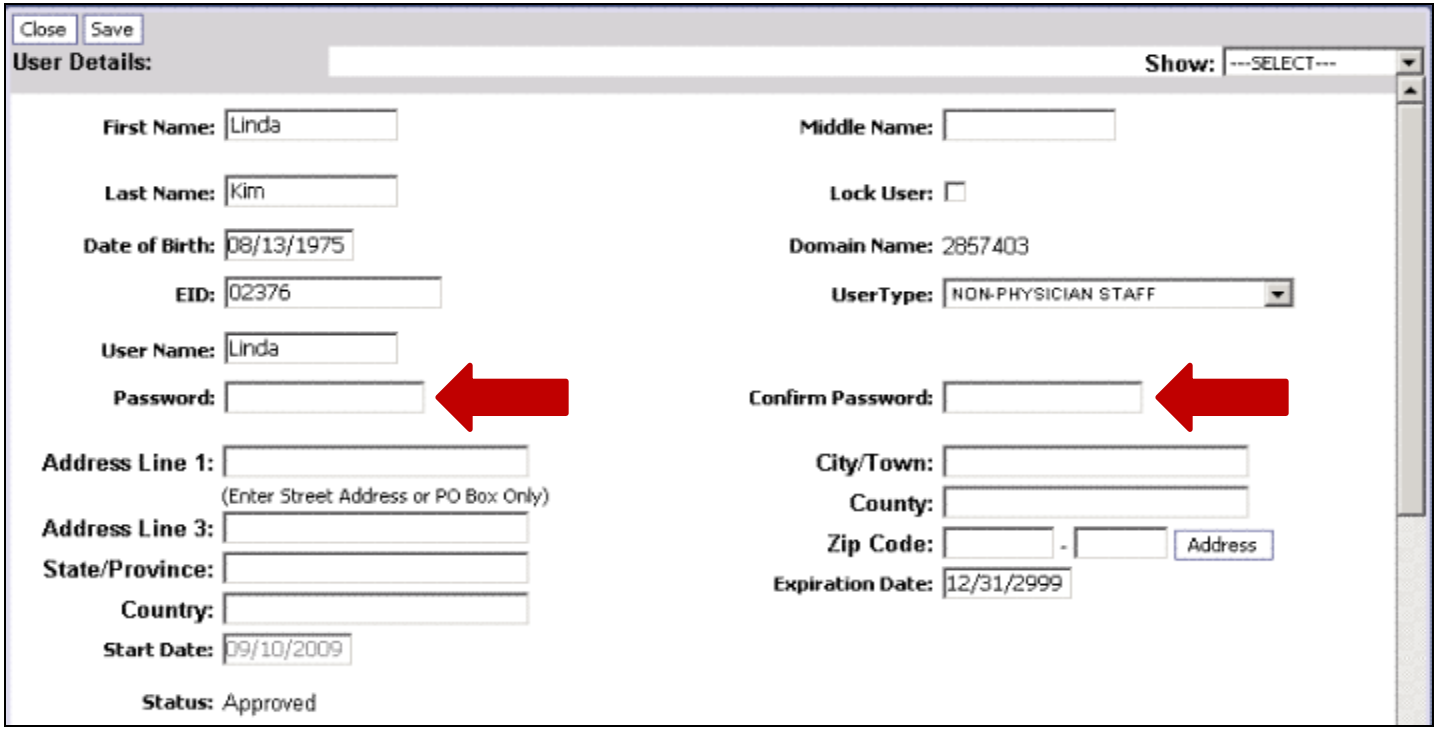
How to Manage a user

- How to lock and unlock a user



How to Manage a user

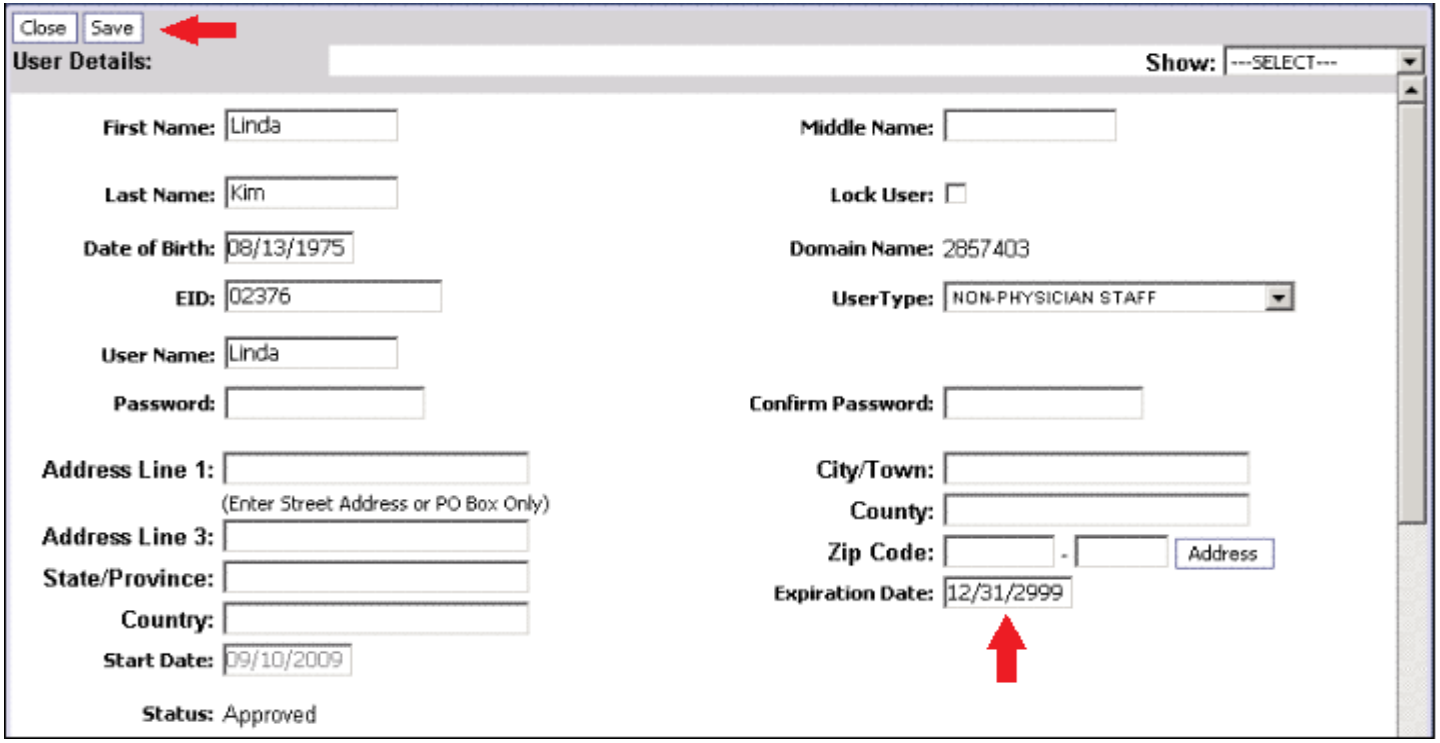
- How to reset a password



- Enter the new temporary password and click **"Save"**

How to Manage a user

- How to end a user in ProviderOne



- ✓ Enter the end date and click the **"Save"** button.
- ✓ The account will be removed from view after the system refreshes overnight.

Direct Data Entry Claims (DDE)

Commercial Insurance Secondary Claims

After this training, you can:

- Submit FFS direct data entry (DDE) claims
- Create and Submit TPL secondary DDE claims
  - ✓ With backup
  - ✓ Without backup
- Submit TPL secondary claims electronically
  - ✓ Without BU
- Bill Medicare crossovers (XO) and commercial private insurance (TPL) on same claim
- No information about pharmacy claims is discussed in this training

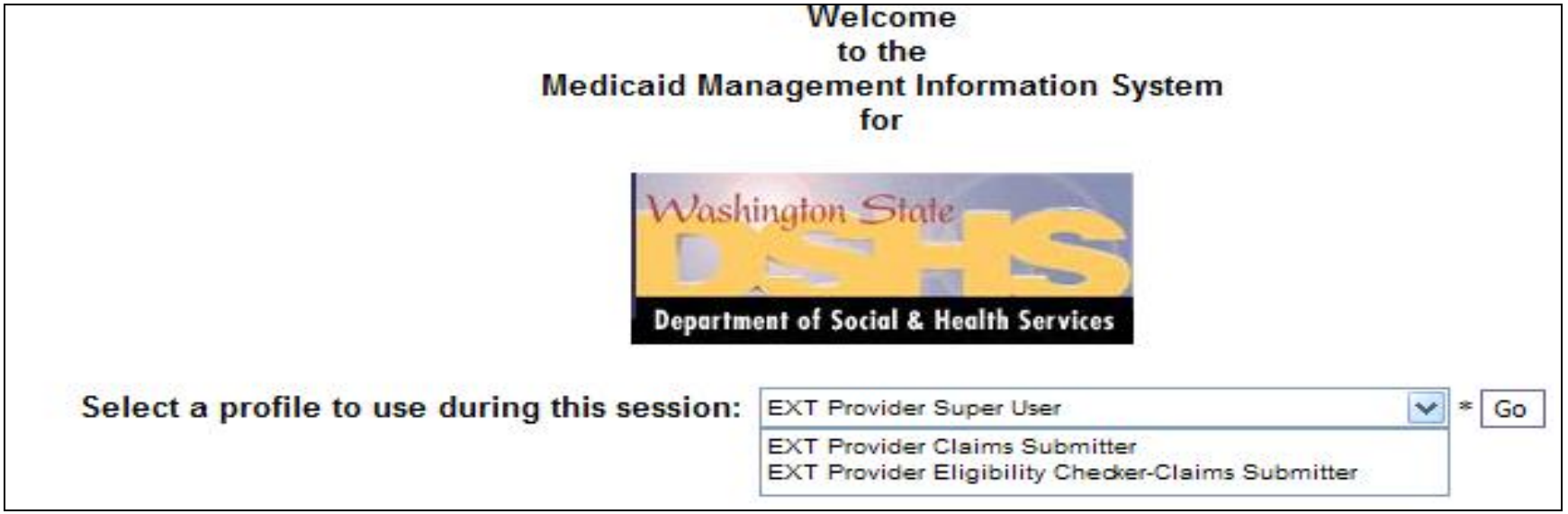
Direct Data Entry Claims (DDE)

- ProviderOne allows providers to enter claims directly into the payment system
- All claim types can be submitted through the DDE system
  - ✓ Professional (CMS 1500)
  - ✓ Institutional (UB-04)
  - ✓ Dental (ADA Form)
- Providers can correct and resubmit denied or previously voided claims
- Providers can ADJUST or VOID previously paid claims

Accessing ProviderOne

- Use web address https://www.waproviderone.org
- Ensure that your system **"Pop Up Blocker"** is turned **"OFF"**
- Login using assigned Domain, Username, and Password
- Click on the **"Login"** button

Determine what profile to use



For claims submission choose one of the following profiles:

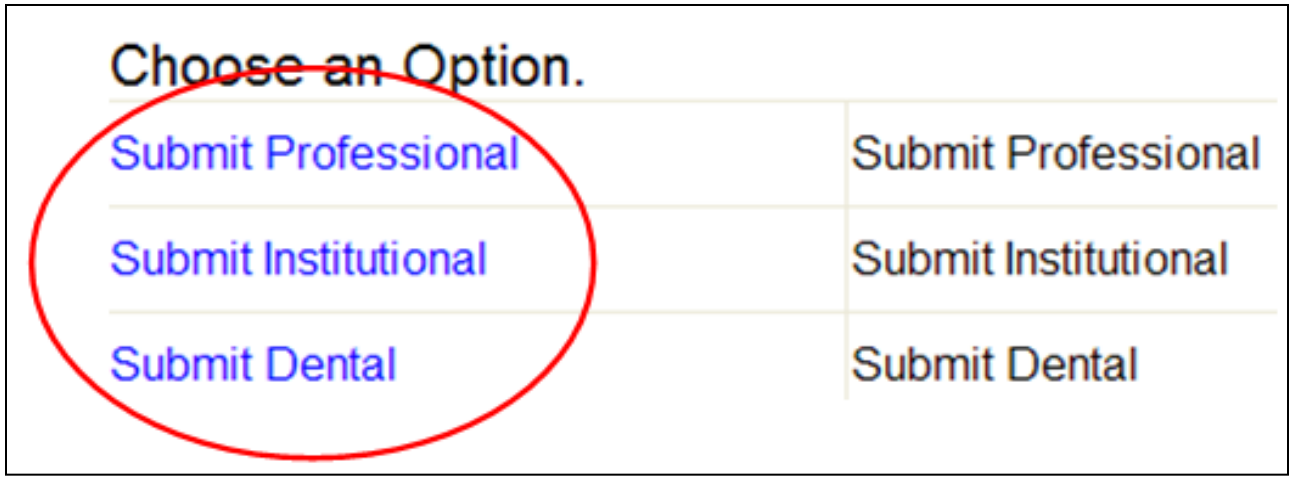
- EXT Provider Super User
- EXT Provider Claims Submitter
- EXT Provider Eligibility Checker – Claims Submitter

Direct Data Entry Claims (DDE)

- From the Provider Portal select the "Online Claims Entry" option located under the "Claims" heading.

Direct Data Entry Claims (DDE)

- Choose the type of claim that you would like to submit.
  - ✓ Professional is the CMS 1500
  - ✓ Institutional is the UB04
  - ✓ Dental is the 2006 ADA form



Direct Data Entry Claims (DDE)

Close | Save Claim | Submit Claim | Reset

Professional Claim:

Note: asterisks (*) denote required fields. Billing Instructions

Basic Claim Info | Other Claim Info

Billing Provider | Rendering Provider | Subscriber | Claim | Service

Submitter ID: 200320900

PROVIDER INFORMATION

Go to Other Claim Info to enter information for Referring, Purchasing, Supervising and other providers.

BILLING PROVIDER

* Provider NPI: * Taxonomy Code:

* Is the Billing Provider also the Rendering Provider? Yes No

* Is this service the result of a referral? Yes No

Top

SUBSCRIBER/CLIENT INFORMATION

SUBSCRIBER/CLIENT

* Client ID:

Additional Subscriber/Client Information

Is this claim for a Baby on Mom's Client ID? Yes No

* Is this a Medicare Crossover Claim? Yes No

OTHER INSURANCE INFORMATION

Top

CLAIM INFORMATION

Go to Other Claim Info to include the following claim detail information:
Specialized Line Services, Miscellaneous Line Data, Line Level Providers, Miscellaneous Line Dates, Test Results or Form Identification Information.

PRIOR AUTHORIZATION

CLAIM NOTE

EPSDT INFORMATION

CONDITION INFORMATION

Direct Data Entry Claims (DDE)

* Is this claim accident related? ○ Yes ○ No

CLAIM DATA

Patient Account No.:

* Place of Service:

Additional Claim Data

Diagnosis Codes: * 1: 2: 3: 4: 5: 6:
7: 8: 9: 10: 11: 12:

Top

BASIC LINE ITEM INFORMATION

Click on Other Svc Info in each line item to include the following additional line item information:
Attachment, Drug, DMERC Condition, Health Services, Test Results, Home Oxygen Therapy, Service Facility, Miscellaneous Numbers, Indicators, Providers, Dates and Amounts, Medical Equipment, Ambulance Transport, Line Item Note, Other Payer, Spinal Manipulations, Purchased Services and Line Adjudication.

BASIC SERVICE LINE ITEMS

* Service Date From: mm dd ccyy

* Service Date To: mm dd ccyy

Place of Service:

* Procedure Code:

Modifiers: 1: 2: 3: 4:

* Submitted Charges: $

Diagnosis Pointers: *1: 2: 3: 4:

* Units:

Medicare Crossover Items

National Drug Code:

Drug Identification

Prior Authorization

Additional Service Line Information

Note: Please ensure you have entered any necessary claim information (found in the other sections on this or another page) before adding this service line.

Add Service Line Item | Update Service Line Item

Billing Provider Information

- Section 1: Billing Provider Information of the DDE Professional claim form

Professional Claim:

Note: asterisks (*) denote required fields.

Basic Claim Info | Other Claim Info

Billing Provider | Rendering Provider | Subscriber | Claim | Service

PROVIDER INFORMATION

Go to Other Claim Info to enter information for Referring, Purchasing, Supervising and other providers.

BILLING PROVIDER

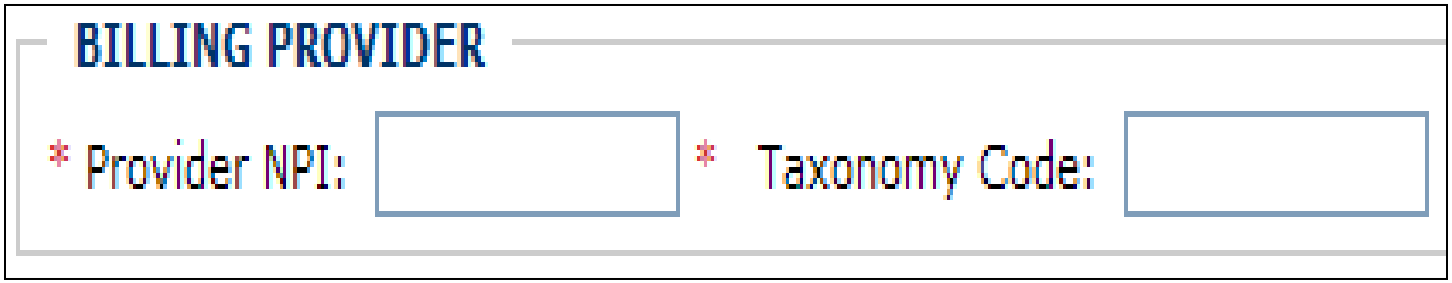
* Provider NPI: * Taxonomy Code:

* Is the Billing Provider also the Rendering Provider? ○ Yes ○ No

* Is this service the result of a referral? ○ Yes ○ No

Billing Provider Information

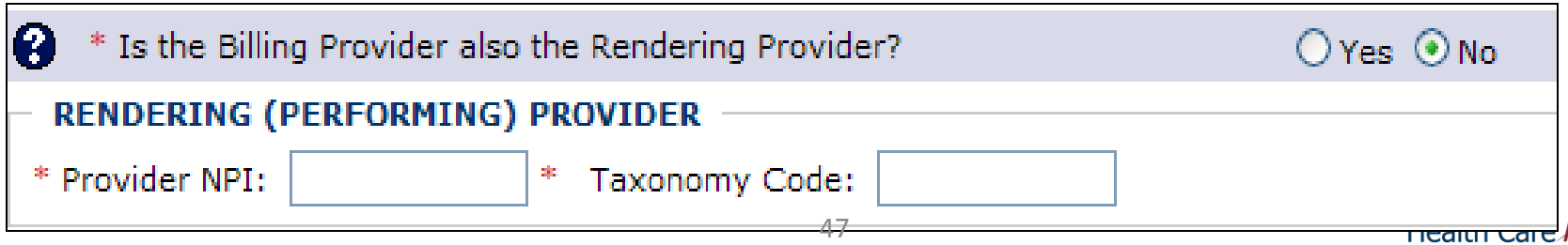
- Enter the Billing Provider NPI and taxonomy code
  - ✓ This will likely be the NPI and Taxonomy Code of the clinic/office where the service was performed and where you would like payment to be received.



Rendering Provider Information

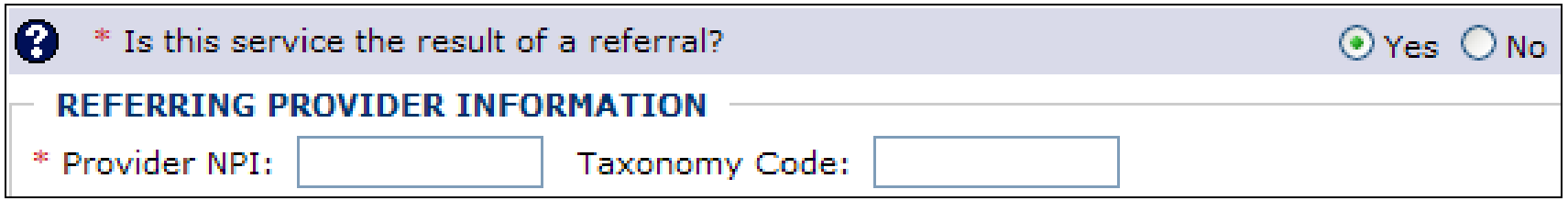
- If the **"Rendering Provider"** is the same as the **"Billing Provider"** you just entered answer the question **"YES"** and go on to the next question.

- If the **"Rendering Provider"** is different than the **"Billing Provider"** you entered in the previous question, answer **"NO"** and enter the **"Rendering (Performing) Provider"** NPI and Taxonomy Code.



Referring Provider Information

- If the service **"Is"** a result of a referral answer **"Yes"** to this question and add the referring provider NPI.



- **Note:** Only the provider NPI number is required for referring providers

- If the service is **"Not"** the result of a referral answer the question **"No"** and continue on to next section.

Subscriber/Client Information

- Section 2: Subscriber/Client Information

SUBSCRIBER/CLIENT INFORMATION

SUBSCRIBER/CLIENT

* Client ID:

Additional Subscriber/Client Information

Is this claim for a Baby on Mom's Client ID? Yes No

* Is this a Medicare Crossover Claim? Yes No

OTHER INSURANCE INFORMATION

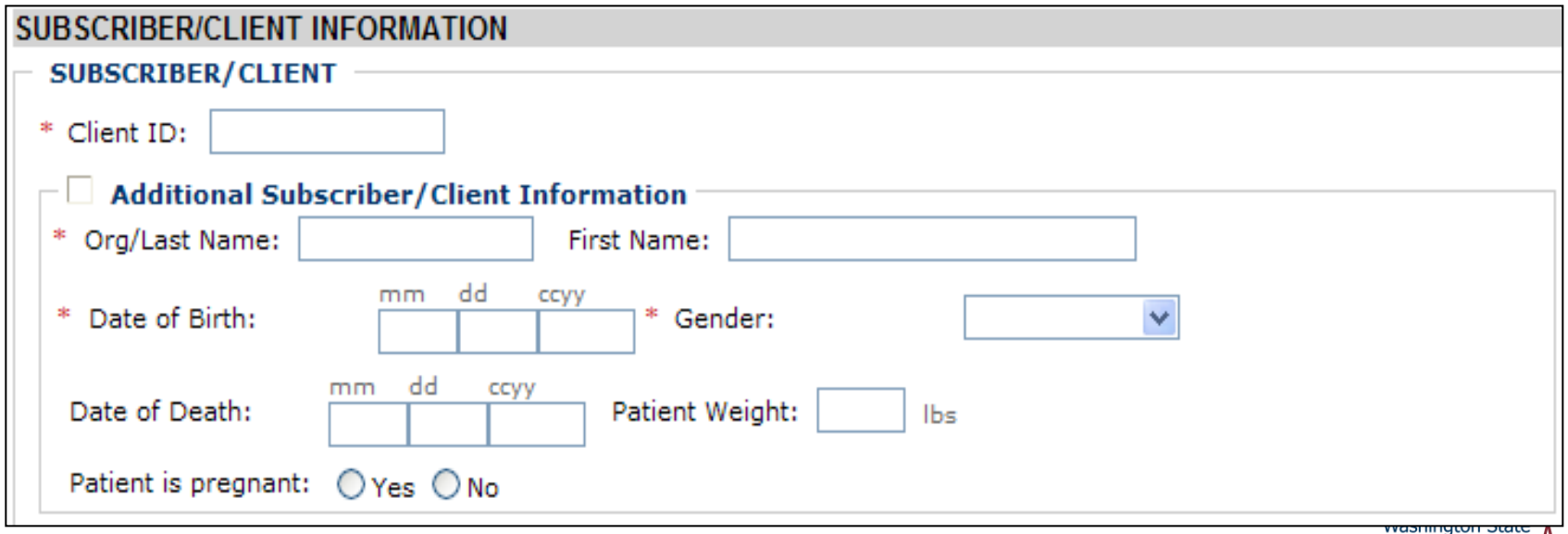
Subscriber/Client Information

- Enter the Subscriber/Client ID found on the WA Medicaid medical card. This ID is a 9 digit number followed by a **"WA"**
  - ✓ Example: 123456789WA

- Click on the red **"+"** to expand the **"Additional Subscriber/Client Information"** to enter required information.

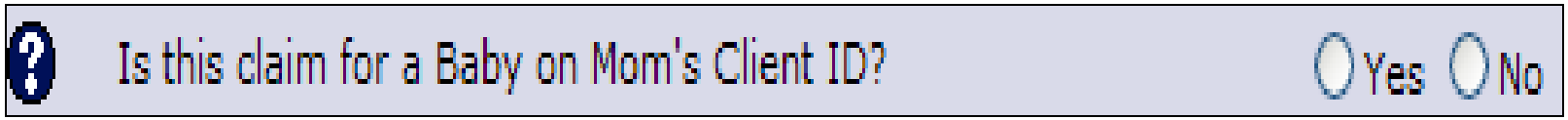
Subscriber/Client Information

- Once the field is expanded enter the **"Patient's Last Name, Date of Birth, and Gender"**.
  - ✓ Date of birth must be in the following format: **MM/DD/CCYY**.
  - ✓ Additional shown information fields are not needed.



Baby on Mom's Client ID

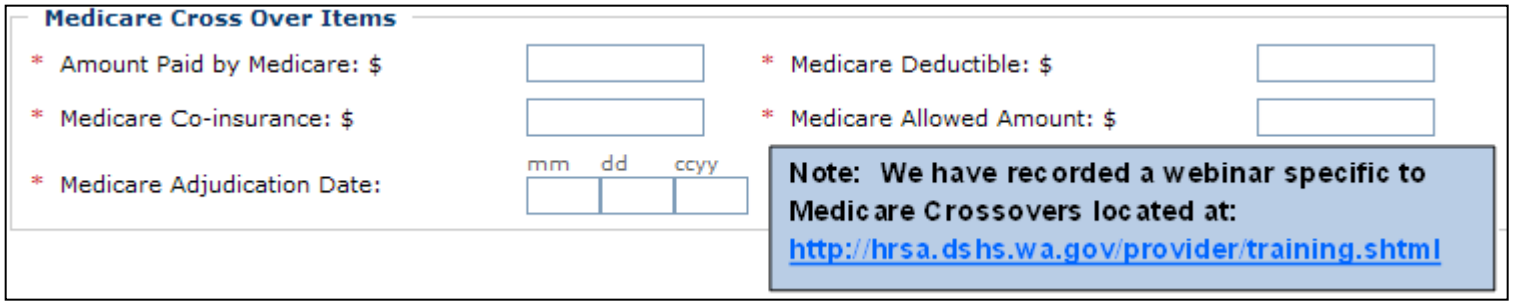
- If claim is for a baby being billed under the mom's ID select **"Yes"** otherwise choose **"No"** and continue to next question.



- **Note:** If claim is for a baby using the mom's ID, use the baby's last name, the baby's date of birth, and gender when filling out the **"Subscriber/Client"** information on previous slide. Be sure to add the claim note **SCI=B** when billing for a baby using mom's ID.

Medicare Crossover Claim

- If the claim is considered a Medicare Crossover answer the question **"YES"**, this includes Managed Medicare Advantage Plans (Medicare Part C)



- **Note:** WA Medicaid considers a claim as a crossover when Medicare allows the service. If Medicare makes a payment, a co-pay/coinsurance should be indicated or if the charges are applied to a deductible, Medicare may not make any payment.

- If Medicare did not make a payment answer the question **"NO"**

Insurance Other Than Medicaid

- If the client has other commercial insurance open the **"Other Insurance Information"** section by clicking on the red **(+)** expander.

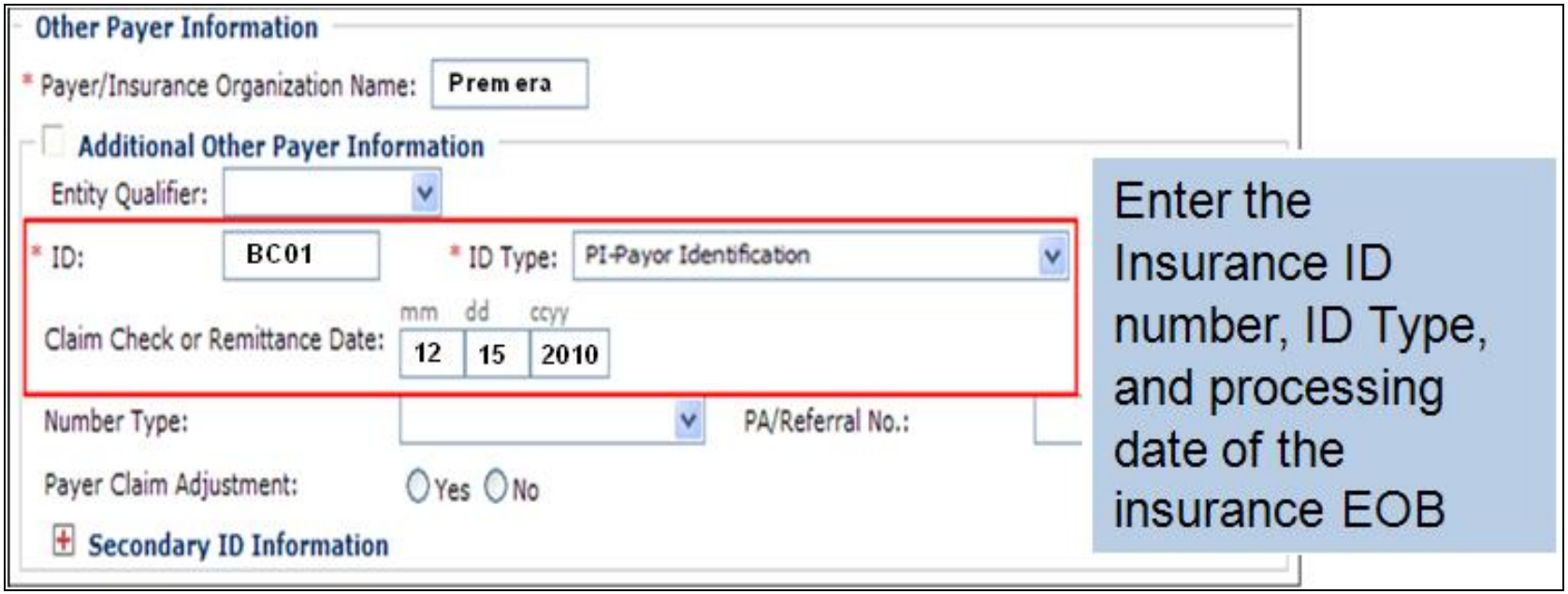
- Then open up the **"1 Other Payer Insurance Information"** section by clicking on the red **(+)** expander.

Insurance Other Than Medicaid

- Enter the **"Payer/Insurance Organization Name"** then
- Open up the **"Additional Other Payer Information"** section by clicking on the red **(+)** expander.

Insurance Other Than Medicaid

- In the **"Additional Other Payer Information"** section fill in the following:



Insurance Other Than Medicaid

- Use the Insurance Carrier Code found on the client eligibility screen under the **"Coordination of Benefits"** section as the **"ID"** number for the insurance company, or

- Use the assigned insurance company ID provided on the insurance EOB

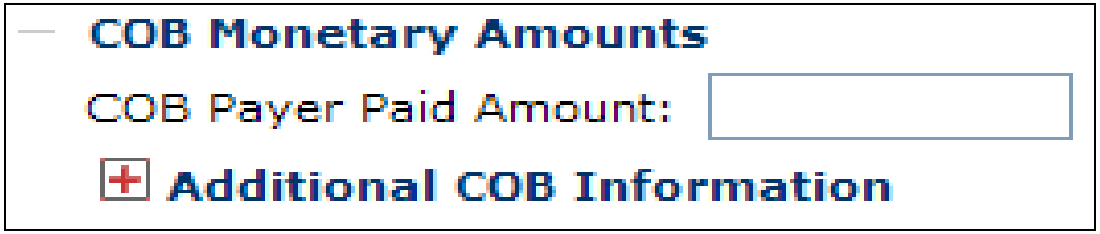
Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	PREMERA BLUE CROSS/BCBS OF AK (800) 345-6784	BC01	SUPER MAN	100883158			03/01/2007	12/31/2999

- See the list of carrier codes at web page http://hrsa.dshs.wa.gov/Download/hcarrier.txt

Insurance Other Than Medicaid

- Enter the total amount paid by the commercial private insurance.

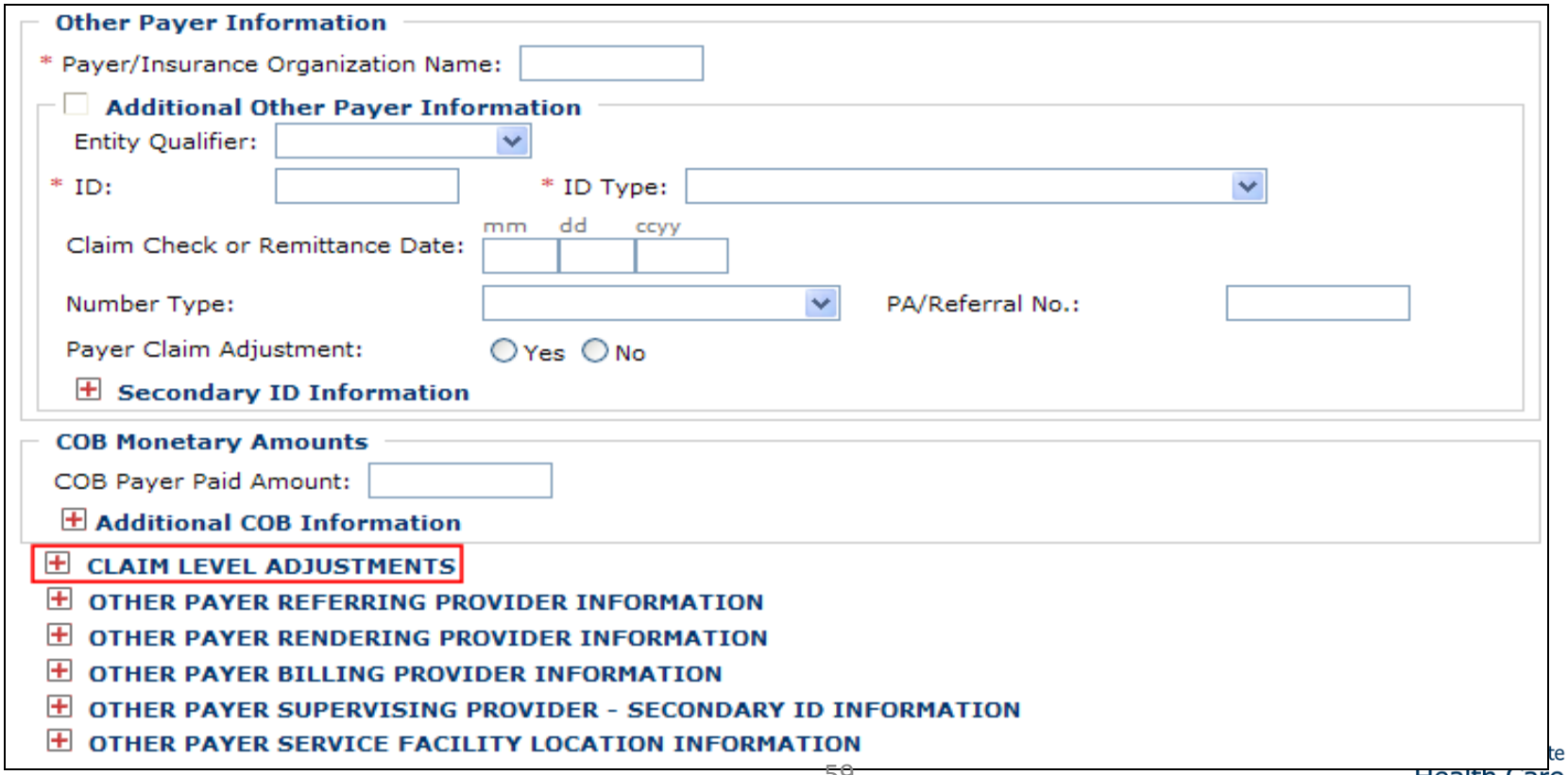


Note: If the insurance applied to the deductible enter a $0 here.

Note: If the claim is for an insurance denial enter a $0 here.

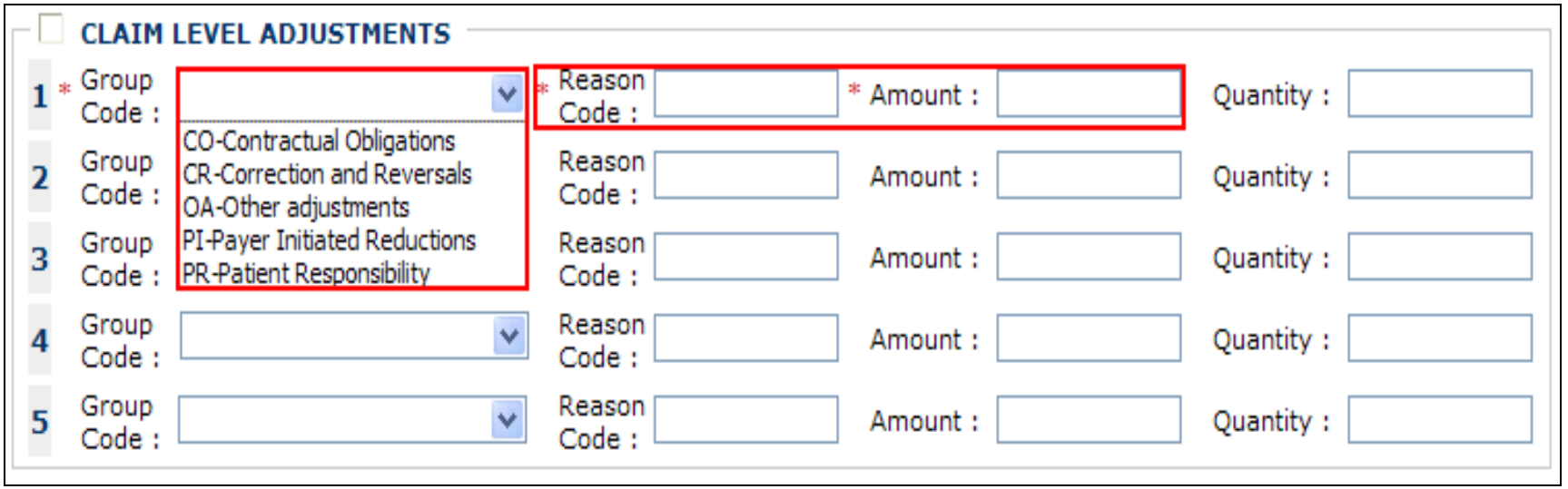
Insurance Other Than Medicaid

- Click on the red **"+"** to expand the **"Claim Level Adjustments"** section.



Insurance Other Than Medicaid

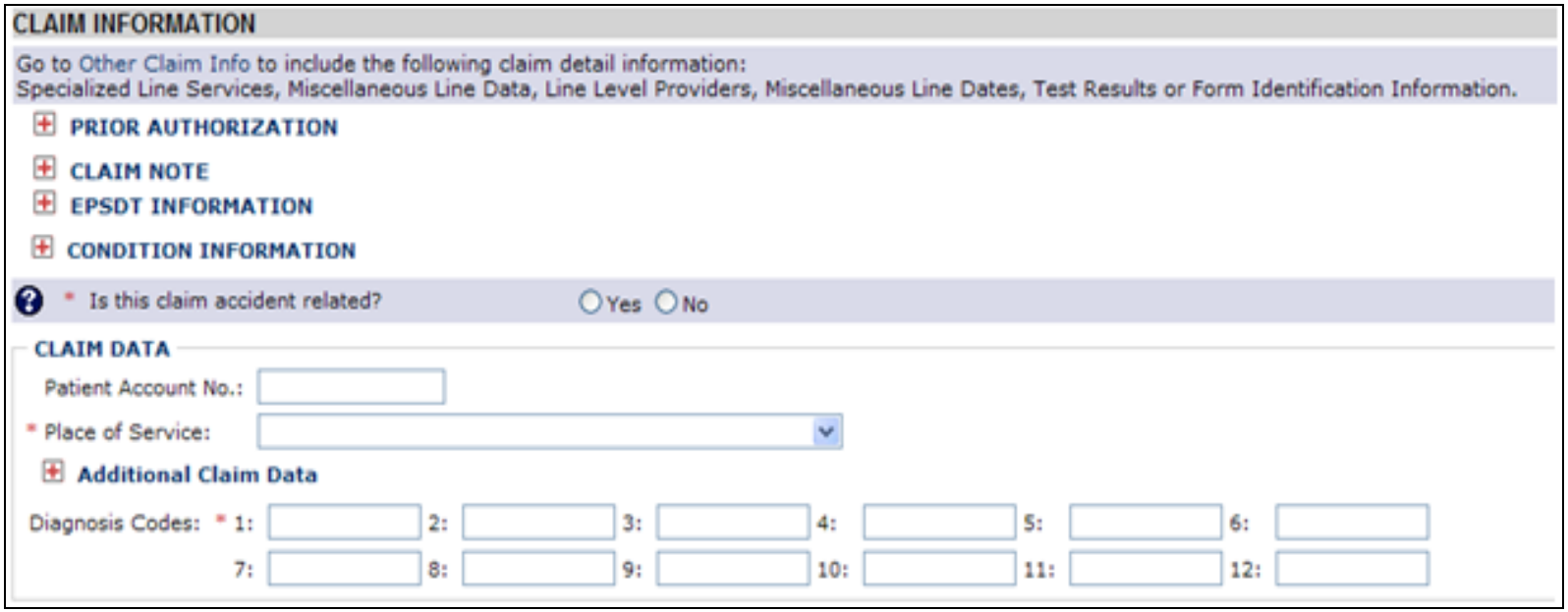
- Enter the adjustment **"Group Code", "Reason Code"** (Number Only), and **"Amount"**



Note: The Agency only accepts the standardized HIPAA compliant group and reason codes. These can be located at the following website: http://www.wpc-edi.com/reference/

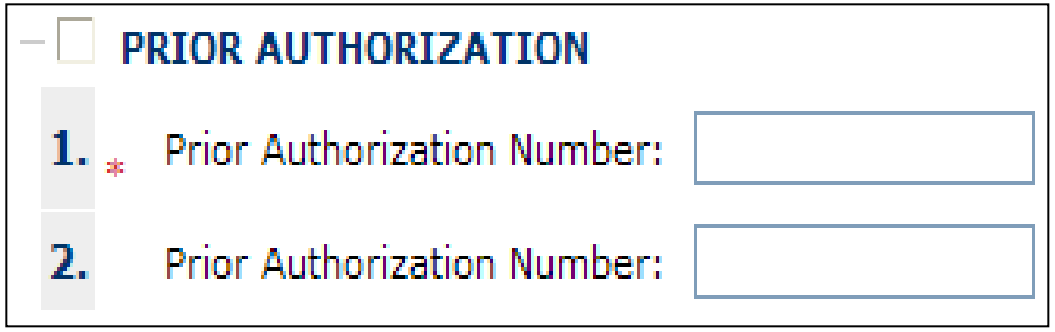
Claim Information

- Section 3: Claim Information Section



Prior Authorization

- If a **"Prior Authorization"** number needs to be added to the claim, click on the red **"+"** to expand the **"Prior Authorization"** fields.
- Expedited Prior Authorization (EPA) numbers are considered authorization numbers and should be entered here.

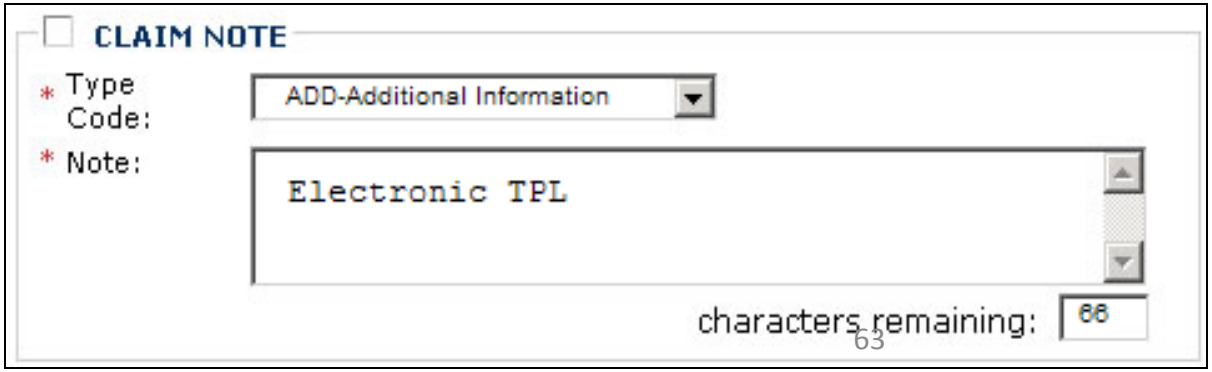


- Note: We recommend that providers enter any authorization number in these boxes. Entering the number here will cover the entire claim.

Claim Note

- A note may to be added to the claim to assist in the processing.

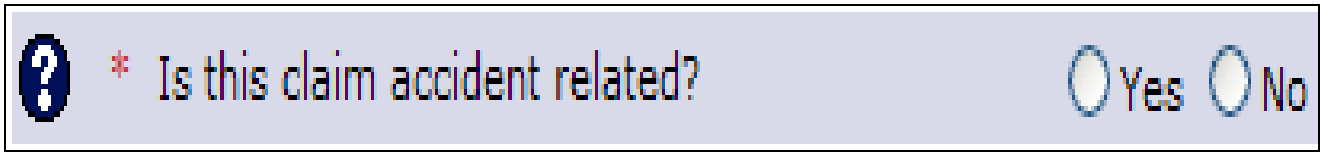
- Click on the red **"+"** to expand the **"Claim Note" section.**
  - ✓ Enter the type Code **"ADD-Additional Information".**
  - ✓ The note must say **"Electronic TPL"** if no EOB is sent.
  - ✓ The note could say **"Sending ins. EOB"** if the EOB is sent
  - ✓ ProviderOne allows up to 80 characters.



Is the Claim Accident Related?

- This question will almost always be answered **"NO"** as Washington Medicaid has a specific casualty office that handles claims where another casualty insurance may be primary.

  - ✓ The Casualty office can be reached at 1-800-562-3022 extension 15462



Patient Account Number

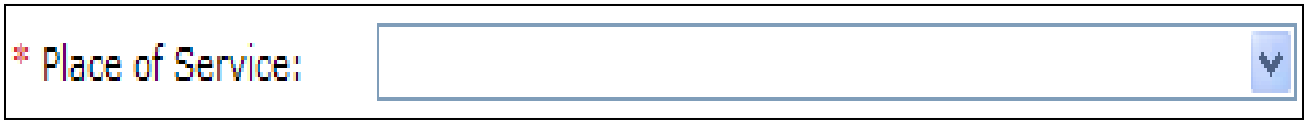
- The **"Patient Account No."** field allows the provider to enter their internal patient account numbers assigned to the patient by their practice management system.

Patient Account No.:

- Note: Entering internal patient account numbers may make it easier to reconcile the weekly remittance and status report (RA) as these numbers will be posted on the RA.

Place of Service

- With 5010 implementation the **"Place of Service"** box has been added to the main claim section. Choose the appropriate **"Place of Service"** from the drop down.



01-PHARMACY
03-SCHOOL
04-HOMELESS SHELTER
05-INDIAN HLTH SVC FREE-STANDING FACILITY
06-INDIAN HLTH SVC PROVIDER-BASED FACILITY
07-TRIBAL 638 FREE-STANDING FACILITY
08-TRIBAL 638 PROVIDER-BASED FACILITY
09-PRISON/CORRECTIONAL FACILITY
11-OFFICE
12-Home
13-ASSISTED LIVING FACILITY
14-Group Home
15-MOBILE UNIT
16-TEMPORARY LODGING
17-WALK-IN RETAIL HEALTH CLINIC
20-URGENT CARE FACILITY
21-INPATIENT HOSPITAL
22-OUTPATIENT HOSPITAL
23-EMERGENCY ROOM - HOSPITAL
24-AMBULATORY SURGICAL CENTER
25-BIRTHING CENTER
26-MILITARY TREATMENT FACILITY
31-SKILLED NURSING FACILITY (SNF)
32-NURSING FACILITY
33-CUSTODIAL CARE FACILITY
34-Hospice
41-AMBULANCE - LAND
42-AMBULANCE - AIR OR WATER
49-INDEPENDENT CLINIC
50-FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
51-INPATIENT PSYCHIATRIC FACILITY
52-PSYCHIATRIC FACILITY - PARTIAL HOSPITALIZATION
53-COMMUNITY MENTAL HEALTH CENTER
54-INTERMEDIATE CARE FACILITY (ICF/MR)
55-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56-PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
57-NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
60-MASS IMMUNIZATION CENTER
61-COMPREHENSIVE INPATIENT REHAB FACILITY
62-COMPREHENSIVE OUTPATIENT REHAB FACILITY
65-END-STAGE RENAL DISEASE TREATMENT FACILITY
71-PUBLIC HEALTH CLINIC
72-RURAL HEALTH CLINIC (RHC)
81-INDEPENDENT LABORATORY
99-OTHER PLACE OF SERVICE

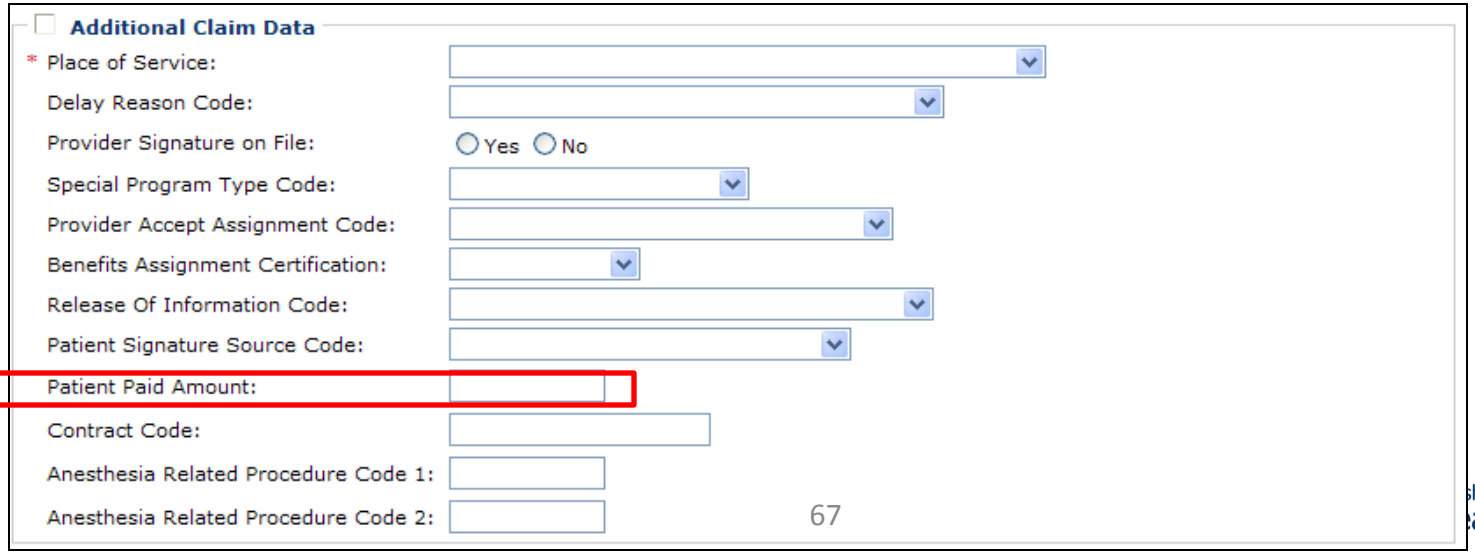
- Note: The **"Place of Service"** is required in this section but can still be added to the line level of the claim. Line level is **not** required.

Additional Claim Data

- The **"Additional Claim Data"** red **(+)** expander will allow the provider to enter the patient's spenddown amount.

+ Additional Claim Data

- If patient has a spenddown click on the red **(+)** expander to display the below image. Enter the spenddown amount in the **"Patient Paid Amount"** box.



Diagnosis Codes

- Enter the appropriate ICD-9 diagnosis code or codes.

Diagnosis Codes: *	1:		2:		3:		4:		5:		6:	
	7:		8:		9:		10:		11:		12:	

- Note:
  - ✓ At least 1 diagnosis code is required for all claims.
  - ✓ ProviderOne will allow up to 12 ICD-9 diagnosis codes.
  - ✓ Do not enter decimal points in DX codes. ProviderOne will add these in once the claim is submitted.

Basic Service Line Items

- Section 4: Basic Line Item Information

BASIC LINE ITEM INFORMATION

Click on Other Svc Info in each line item to include the following additional line item information:
Attachment, Drug, DMERC Condition, Health Services, Test Results, Home Oxygen Therapy, Service Facility, Miscellaneous Numbers, Indicators, Providers, Dates and Amounts, Medical Equipment, Ambulance Transport, Line Item Note, Other Payer, Spinal Manipulations, Purchased Services and Line Adjudication.

BASIC SERVICE LINE ITEMS

* Service Date From: mm dd ccyy

Service Date To: mm dd ccyy

Place of Service:

* Procedure Code:

Modifiers: 1: 2: 3: 4:

* Submitted Charges: $

Diagnosis Pointers: *1: 2: 3: 4:

* Units:

Medicare Crossover Items

National Drug Code:

Drug Identification

Prior Authorization

Additional Service Line Information

Note: Please ensure you have entered any necessary claim information (found in the other sections on this or another page) before adding this service line.

Add Service Line Item | Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $

Line No	Service Dates From	Service Dates To	Proc. Code	Modifiers 1	Modifiers 2	Modifiers 3	Modifiers 4	Diagnosis Ptrs 1	Diagnosis Ptrs 2	Diagnosis Ptrs 3	Diagnosis Ptrs 4	Submitted Charges	Units	PA Number

Basic Service Line Items

- Enter the "From Service Date"

* Service Date From:	mm	dd	ccyy

- Enter the "To Service Date"

* Service Date To:	mm	dd	ccyy

- Note: The dates of service must be in the format of 2 digit month, 2 digit day, and 4 digit year, for example 10/03/2011.

Basic Service Line Items

- **Optional** "Place of Service Code" (Not required here as already entered)

Place of Service:

- **Note:** Use the "Blue Arrow" drop down to display all POS codes loaded in ProviderOne.

- POS codes available:

01-PHARMACY
03-SCHOOL
04-HOMELESS SHELTER
05-INDIAN HLTH SVC FREE-STANDING FACILITY
06-INDIAN HLTH SVC PROVIDER-BASED FACILITY
07-TRIBAL 638 FREE-STANDING FACILITY
08-TRIBAL 638 PROVIDER-BASED FACILITY
09-PRISON/CORRECTIONAL FACILITY
11-OFFICE
12-Home
13-ASSISTED LIVING FACILITY
14-Group Home
15-MOBILE UNIT
16-TEMPORARY LODGING
17-WALK-IN RETAIL HEALTH CLINIC
20-URGENT CARE FACILITY
21-INPATIENT HOSPITAL
22-OUTPATIENT HOSPITAL
23-EMERGENCY ROOM - HOSPITAL
24-AMBULATORY SURGICAL CENTER
25-BIRTHING CENTER
26-MILITARY TREATMENT FACILITY
31-SKILLED NURSING FACILITY (SNF)
32-NURSING FACILITY
33-CUSTODIAL CARE FACILITY
34-Hospice
41-AMBULANCE - LAND
42-AMBULANCE - AIR OR WATER
49-INDEPENDENT CLINIC
50-FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
51-INPATIENT PSYCHIATRIC FACILITY
52-PSYCHIATRIC FACILITY - PARTIAL HOSPITALIZATION
53-COMMUNITY MENTAL HEALTH CENTER
54-INTERMEDIATE CARE FACILITY (ICF/MR)
55-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56-PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
57-NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
60-MASS IMMUNIZATION CENTER
61-COMPREHENSIVE INPATIENT REHAB FACILITY
62-COMPREHENSIVE OUTPATIENT REHAB FACILITY
65-END-STAGE RENAL DISEASE TREATMENT FACILITY
71-PUBLIC HEALTH CLINIC
72-RURAL HEALTH CLINIC (RHC)
81-INDEPENDENT LABORATORY
99-OTHER PLACE OF SERVICE

Basic Service Line Items

- Enter the "Procedure Code"

* Procedure Code:	

- Note: Use current codes listed in the coding manuals.

- Enter the appropriate procedure **"Modifier(s)"** if needed.

Modifiers:	1:		2:		3:		4:	

- Note: ProviderOne allows up to 4 Modifiers to be added to a single procedure code.

Basic Service Line Items

- Enter **"Submitted Charges"**

* Submitted Charges: $

- Note: If dollar amount is a whole number no decimal point is needed.

- Note: The Agency request providers to enter their usual and accustom charges here. If providers have billed a Commercial Insurance or Medicare primary, please enter the same charges here as billed to the primary. If a provider is billing for DME supplies that required prior authorization, please enter the same amount here as was on the authorization request because they must match.

Basic Service Line Items

- Enter appropriate "Diagnosis Pointer"

- Note:
  - ✓ At least one DX pointer is required.
  - ✓ Up to 4 DX codes can be added per service line.
  - ✓ Diagnosis Pointer 1 is the primary DX code.
  - ✓ Diagnosis Pointer drop down corresponds with DX codes entered previously.

Basic Service Line Items

- Enter procedure "Units"

- Note: At least 1 unit is required

Basic Service Line Items

- If the claim is a "Medicare Crossover" claim complete the following:

Medicare Crossover Items

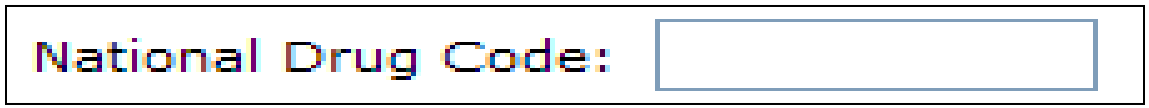
* Medicare Deductible:	$	* Medicare Coinsurance:	$
* Medicare Paid:	$	* Medicare Allowed Amount:	$
* Medicare Paid Date:	mm dd ccyy		

- Note: Entering the line level Medicare information is required here if the previous question concerning Medicare Crossovers was answered yes. The line level Medicare payment data sum must match the claim level Medicare payment data entered.

- Note: For complete instructions on how to submit a Medicare Crossover claim please view the online webinar and presentation slides at http://hrsa.dshs.wa.gov/provider/training.shtml

Basic Service Line Items

- Enter **"National Drug Code"** (NDC) if billing an injectable procedure code.



- The **"Drug Identification"** red **(+)** expander is not needed when billing for injectable procedure codes.

Basic Service Line Items

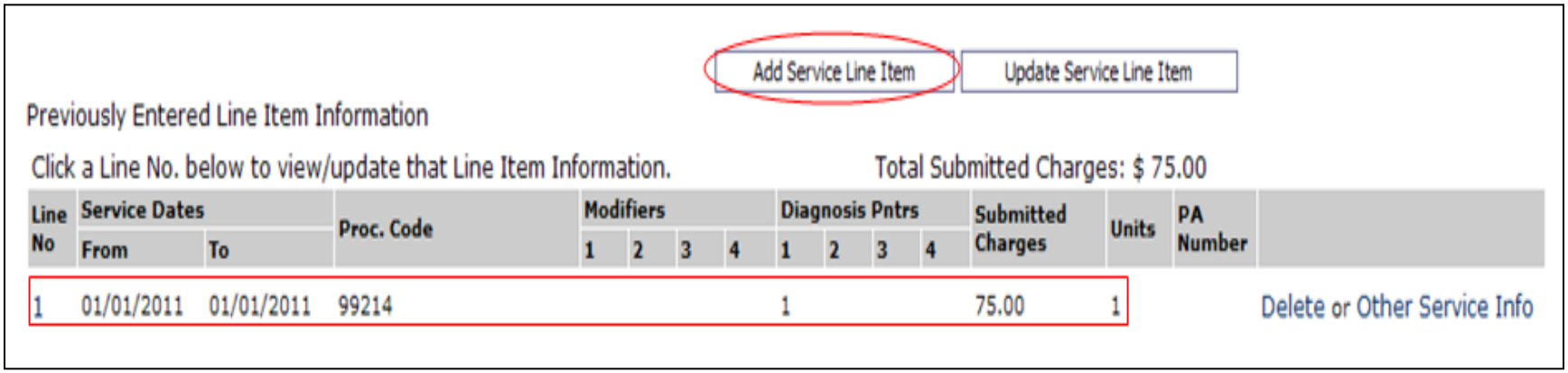
- If a **"Prior Authorization"** number needs to be added to a line level procedure code, click on the red **"+"** to expand the **"Prior Authorization"** option.

- Note: If a Prior Authorization number was entered previously on the claim it is not necessary to enter it again here.

- The **"Additional Service Line Information"** is not needed for claims submission.

Add Service Line Items

➢ Click on the **"Add Service Line Item"** button to list the procedure line on the claim.

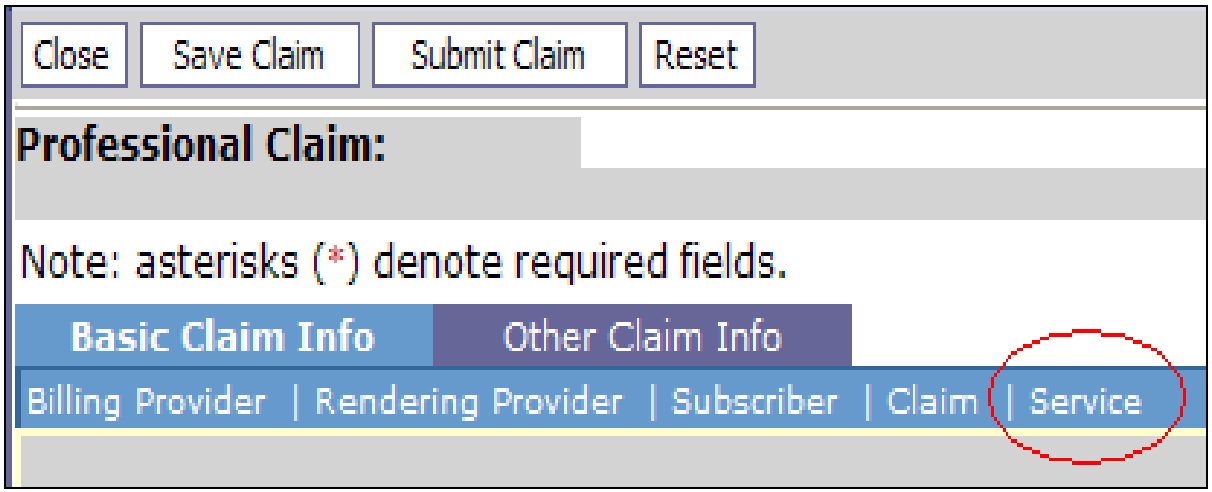


➢ Note: Please ensure all necessary claim information has been entered before clicking the **"Add Service Line Item"** button to add the service line to the claim.

➢ Note: Once the procedure line item is added, ProviderOne will refresh and return to the top of the claim form.

Add Additional Service Line Items

- If additional service lines need to be added, click on the **"Service"** hyperlink to get quickly back to the **"Basic Service Line Items"** section.



- Then follow the same procedure as outlined above for entering data for each line.

Update Service Line Items

- Update a previously added service line item by clicking on the line number of line that needs to be updated. This will repopulate the service line item boxes for changes to be made.

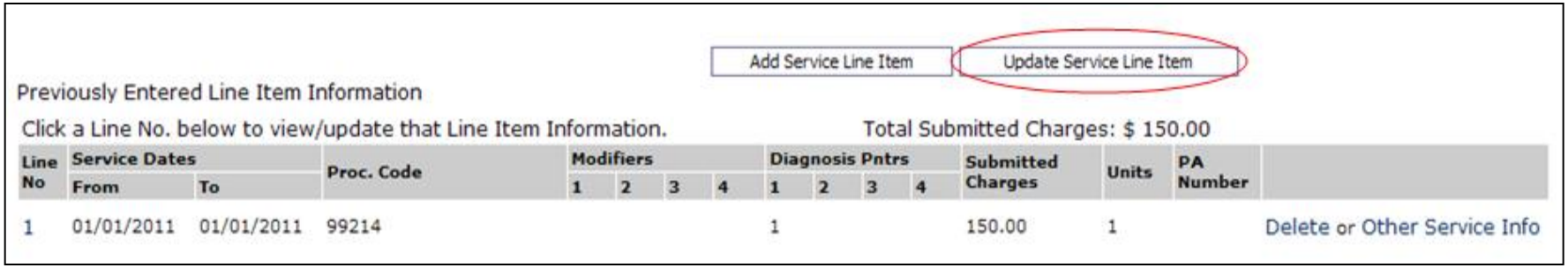
Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 75.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	01/01/2011	01/01/2011	99214					1				75.00	1		Delete or Other Service Info

- Note: Once the line number is chosen, ProviderOne will refresh screen and return to the top of the claim form. Use the "Service" hyperlink to quickly return to the service line item boxes and make corrections.

Update Service Line Items

- Once the service line is corrected, click on the **"Update Service Line Item"** button to add corrected information on claim.



- Note: Once the **"Update Service Line Item"** button is chosen, ProviderOne will refresh screen and return to the top of the claim form. Use the **"Service"** hyperlink to quickly return to the service line item section to view and verify that changes were completed.

Delete Service Line Items

- A service line can easily be **"Deleted"** from claim before submission by clicking on the **"Delete"** option at the end of the added service line.

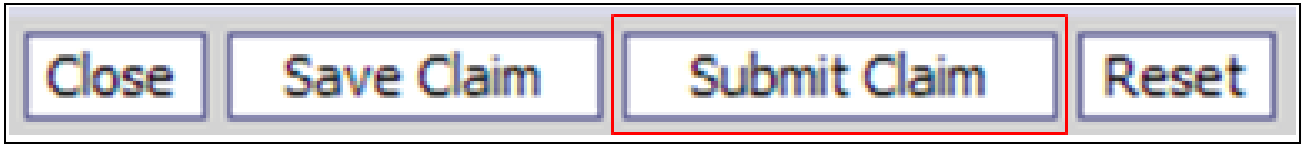
Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 150.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	01/01/2011	01/01/2011	99214					1				150.00	1		Delete or Other Service Info

- Note: Once the service line item is deleted it will be permanently removed from claim. If the service line was accidently deleted the provider will need to re-enter the information following previous instructions.

Submit Claim for Processing

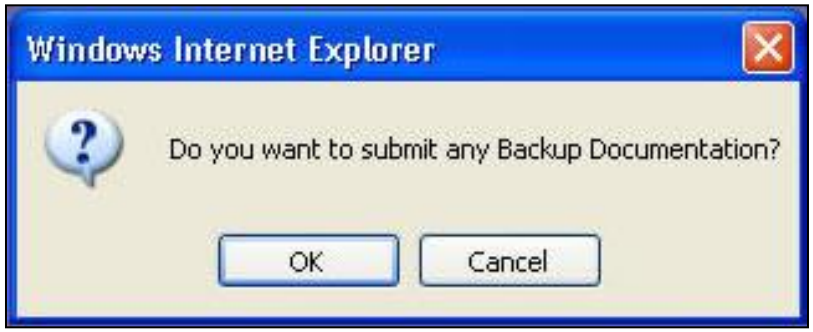
- When the claim is ready for processing, click the **"Submit Claim"** button at the top of the claim form.



- Note: Make sure the browser **"Pop Up Blocker"** is **OFF** or the system will not allow the claim to be submitted.

Submit Claim for Processing

- After the **"Submit Claim"** button is pushed the following **"Pop Up"** is displayed

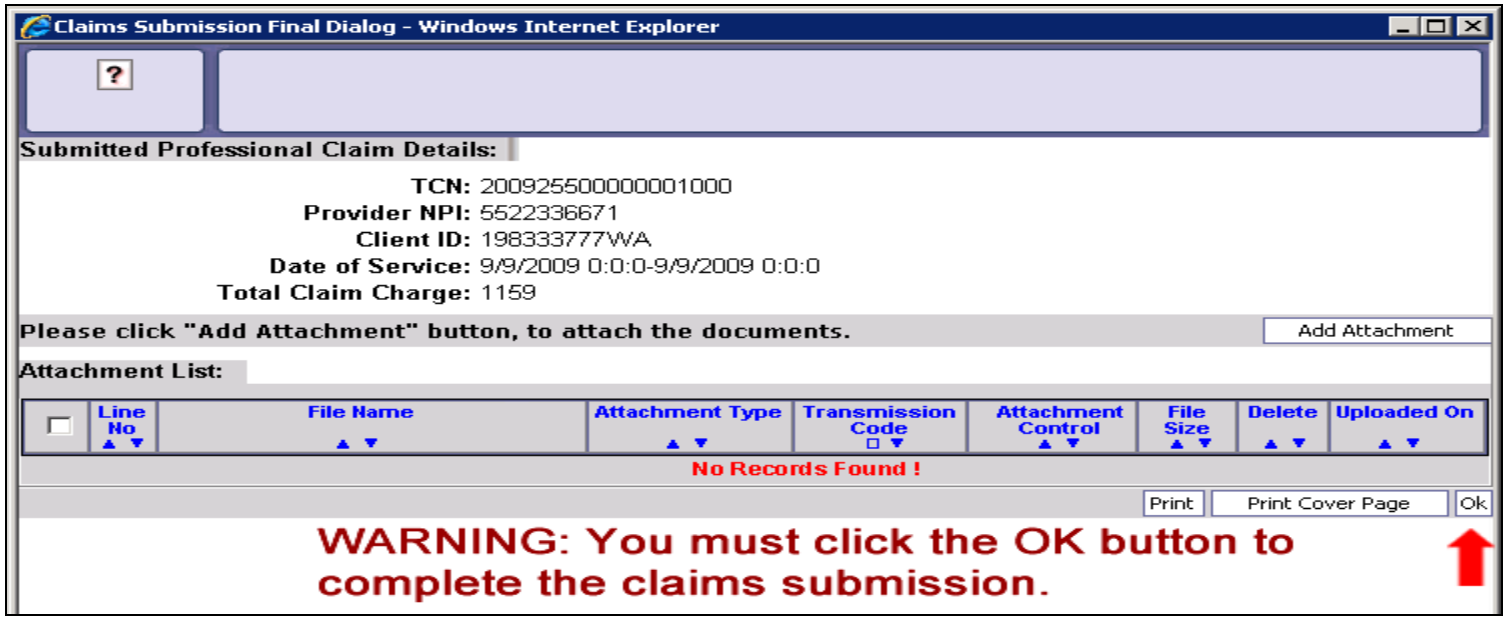


- Click on the **"Cancel"** button if no backup is to be sent.
- Click on **"OK"** if backup needs to be attached.

- Note: If all insurance information has been entered on the claim, it is not necessary to send the insurance EOB with the claim.

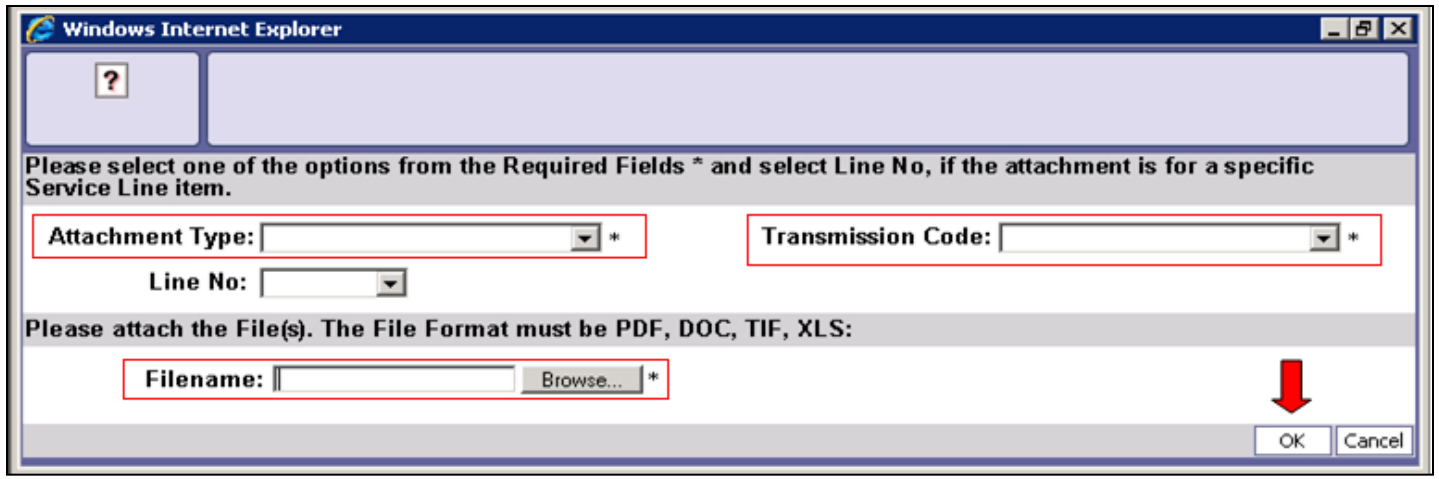
Submit Claim for Processing – No Backup

- ProviderOne now displays the "Submitted Professional Claim Detail" screen
- Click on the "OK" button to finish submitting the claim



Submit Claim for Processing – With Backup (Electronic File Attached)

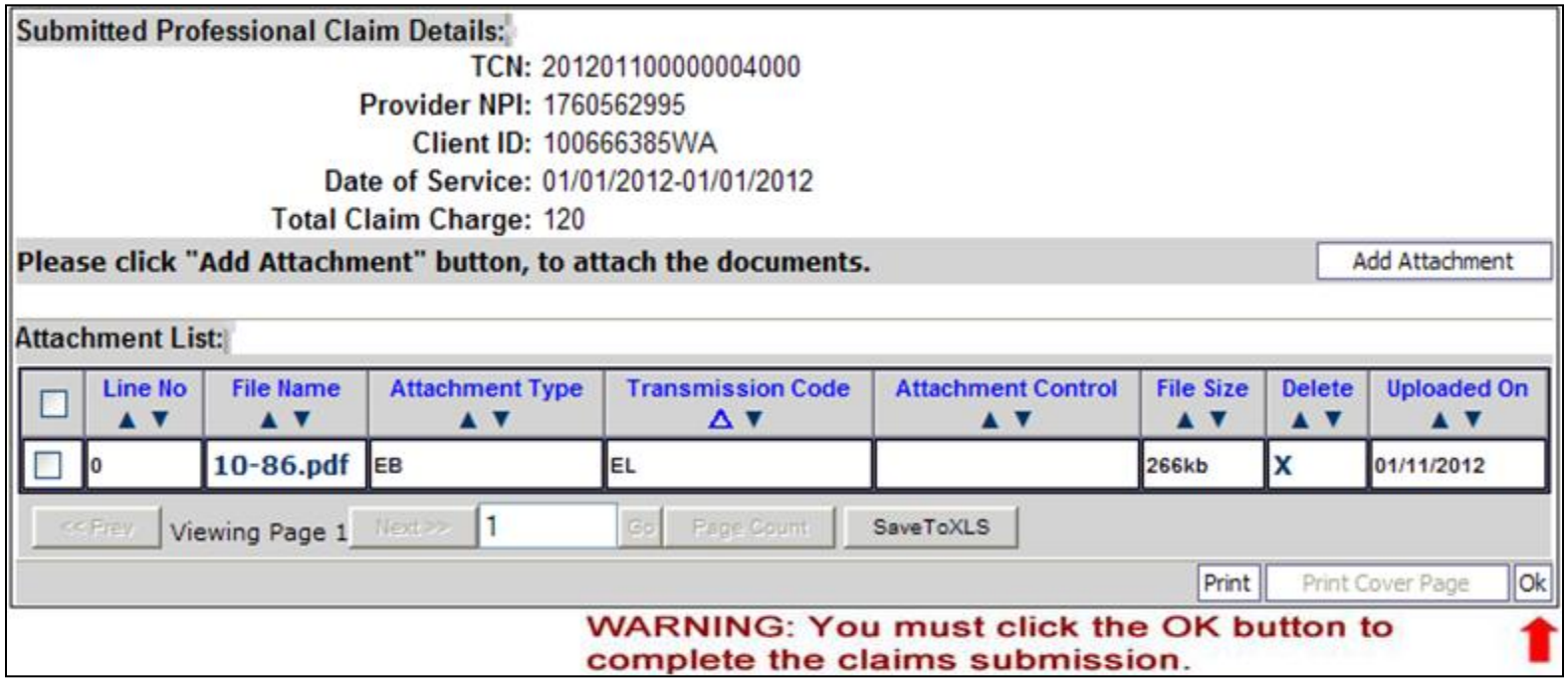
- The **"Claims Backup Documentation"** page is displayed



- ✓ Enter the Attachment Type
- ✓ Pick one of the following Transmission Codes:
  - •EL-Electronic Only or Electronic file,
  - •Then browse to find the file name
- ✓ Click the **"OK"** button

Submit Claim for Processing – With Backup (Electronic File Attached)

- The **"Submitted Professional Claim Details"** page is then displayed.



Submitted Professional Claim Details:

TCN: 201201100000004000
Provider NPI: 1760562995
Client ID: 100666385WA
Date of Service: 01/01/2012-01/01/2012
Total Claim Charge: 120

Please click "Add Attachment" button, to attach the documents. [Add Attachment]

Attachment List:

	Line No	File Name	Attachment Type	Transmission Code	Attachment Control	File Size	Delete	Uploaded On
☐	0	10-86.pdf	EB	EL		266kb	X	01/11/2012

<<Prev Viewing Page 1 Next>> 1 Go Page Count SaveToXLS

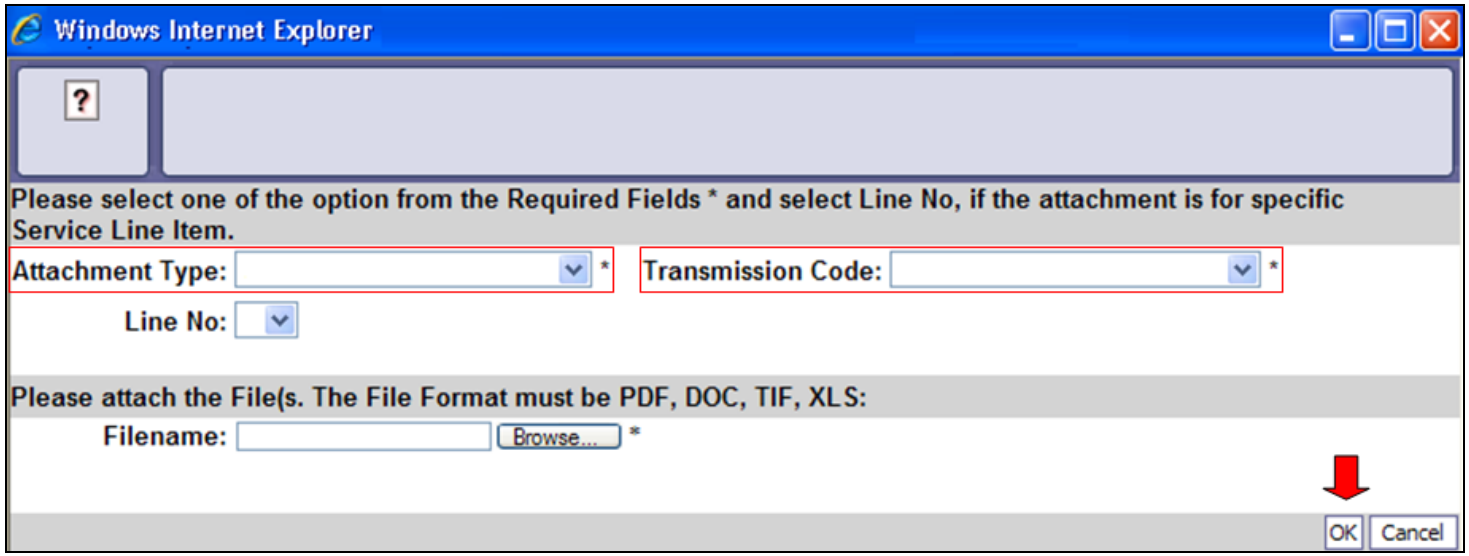
Print Print Cover Page Ok

WARNING: You must click the OK button to complete the claims submission.

- Now push the **"OK"** button to submit the claim.

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- The **"Claims Backup Documentation"** page is displayed.



- ✓ Enter the Attachment Type
- ✓ Pick one of the following Transmission Codes:
  - •BM : By Mail
  - •FX : Fax
- ✓ Click the **"OK"** button

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- If sending paper documents with the claim, at the **"Submitted Professional Claim Details"** page click on the **"Print cover Page"** button.

Submitted Professional Claim Details:

TCN: 201127300000014000
Provider NPI: 1342222999
Client ID: 300655596WA
Date of Service: 10/20/2010-10/20/2010
Total Claim Charge: 75

Please click "Add Attachment" button, to attach the documents. Add Attachment

Attachment List:

	Line No	File Name	Attachment Type	Transmission Code	Attachment Control	File Size	Delete	Uploaded On
☐	0	BM	EB	BM		0kb	X	09/30/2011

<< Prev | Viewing Page 1 | Next >> | 1 | Go | Page Count | SaveToXLS

Print | Print Cover Page | Ok

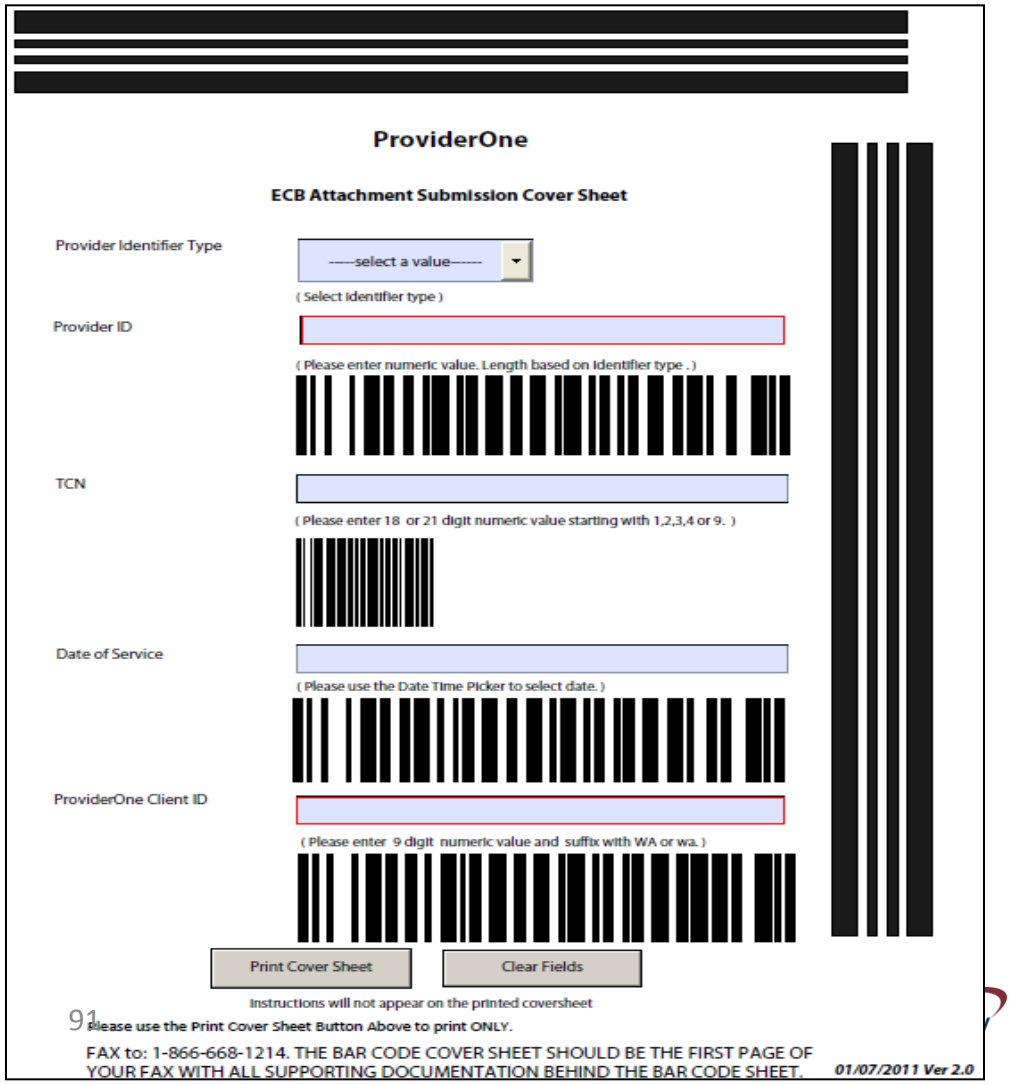
Submit Claim for Processing – With Backup

- Fill in the boxes with the appropriate information. When completed click on the **"Print Cover Sheet"** and mail to:

Electronic Claim Back-up Documentation
PO BOX 45535
Olympia, WA 98504-5535

OR

Fax 1-866-668-1214



ProviderOne

ECB Attachment Submission Cover Sheet

Provider Identifier Type: -----select a value------
(Select identifier type)

Provider ID
(Please enter numeric value. Length based on identifier type .)

TCN
(Please enter 18 or 21 digit numeric value starting with 1,2,3,4 or 9.)

Date of Service
(Please use the Date Time Picker to select date.)

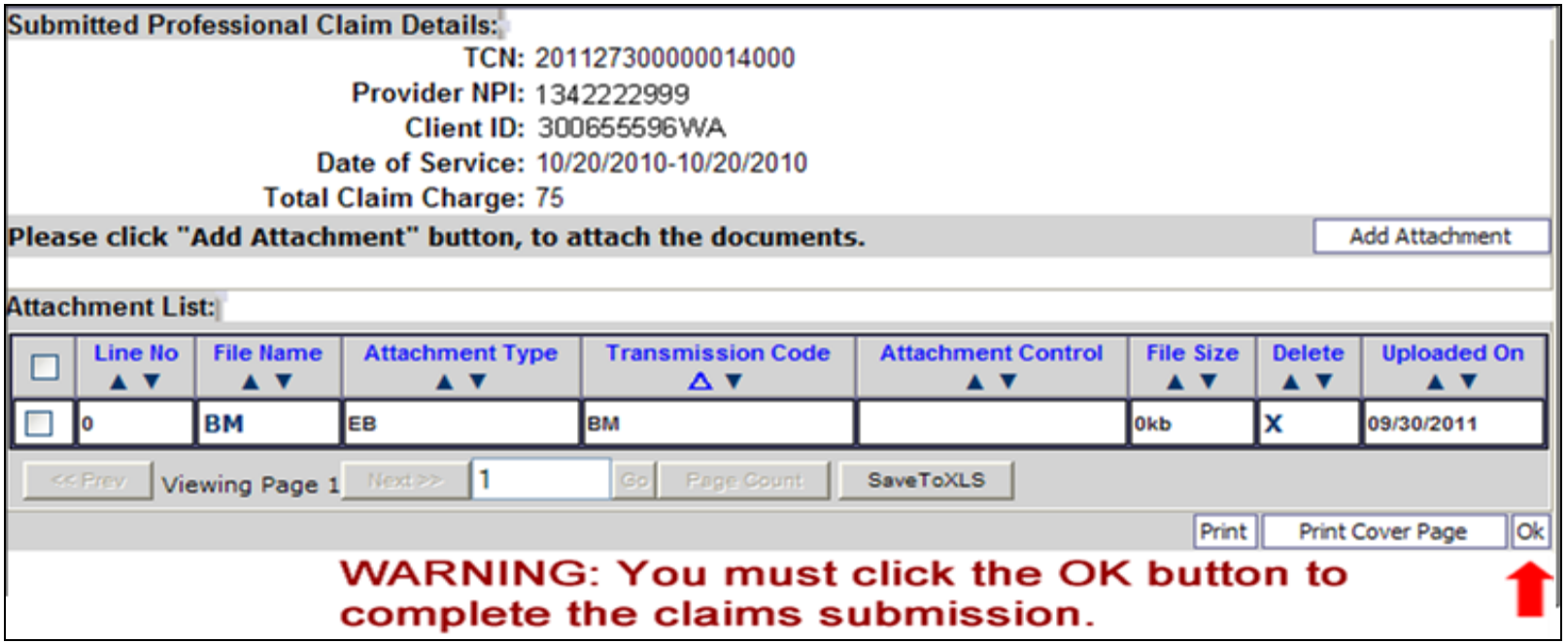
ProviderOne Client ID
(Please enter 9 digit numeric value and suffix with WA or wa.)

Print Cover Sheet | Clear Fields

Instructions will not appear on the printed coversheet
Please use the Print Cover Sheet Button Above to print ONLY.
FAX to: 1-866-668-1214. THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET.
01/07/2011 Ver 2.0

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- Now push the **"OK"** button to submit the claim



Batch Secondary Electronic Billing

- The Agency is accepting secondary electronic claim billing through a clearinghouse batch or a self submitted HIPAA claim batch.
- Add the required comment "Electronic TPL" in Loop 2300 NTE Segment.
- Add the required Adjustment Reason Code information (Loop information located on the above pages in the companion guides).

Saving a Direct Data Entry (DDE) Claim

Saving a Direct Data Entry Claim

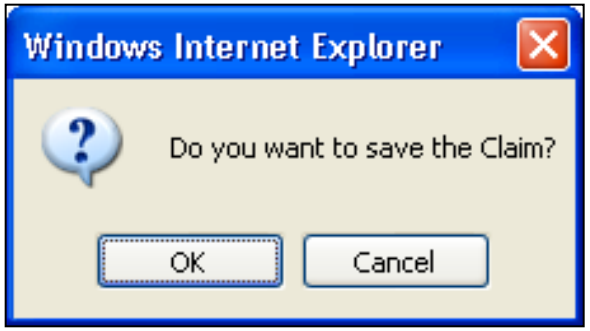
- ProviderOne now allows a provider to save a claim if the provider is interrupted during the process of entering a claim, and allows retrieving that saved claim to finish and submit the claim. The following data elements are at minimum required to be completed before a claim can be saved:

Provider Information • Billing Provider NPI • Billing Provider Taxonomy • Question: Is the Billing Provider also the Rendering Provider? • Question: Is this service the result of a referral?	**Subscriber/Client Information** • Client ID number • Question: Is this a Medicare Crossover Claim?
Claim Information • Question: Is this claim accident related?	**Basic Service Line Items** • Line Items are not required for saving a claim.

Saving a Direct Data Entry Claim

- Save the claim by clicking on the "Save Claim" button.

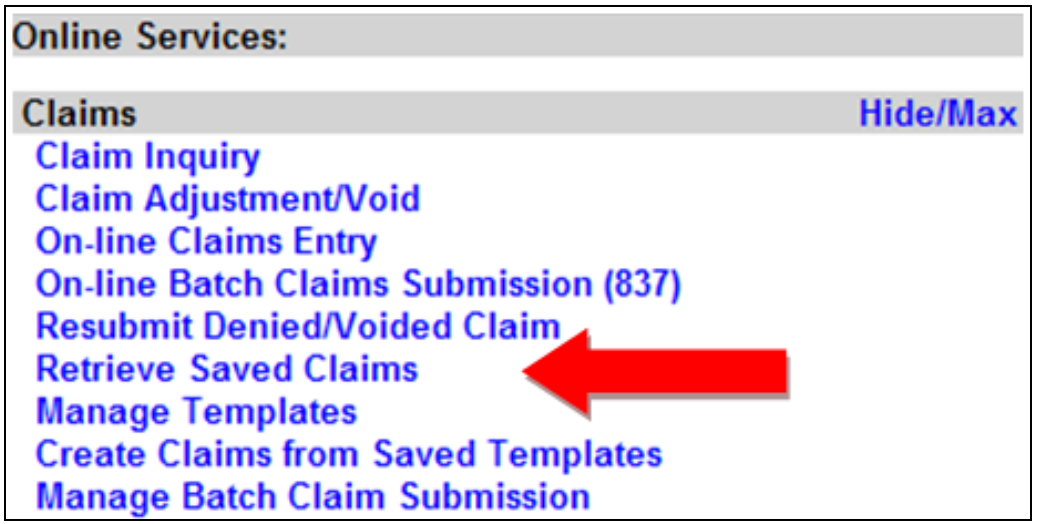
- ProviderOne now displays the following confirmation box:



- Click the **"OK"** button to proceed or Cancel to return to the claim form.
- Once the **"OK"** button is clicked, ProviderOne checks the claim to make sure the minimum data fields are completed.
- If all data fields are completed, ProviderOne saves the claim and closes the claim form.

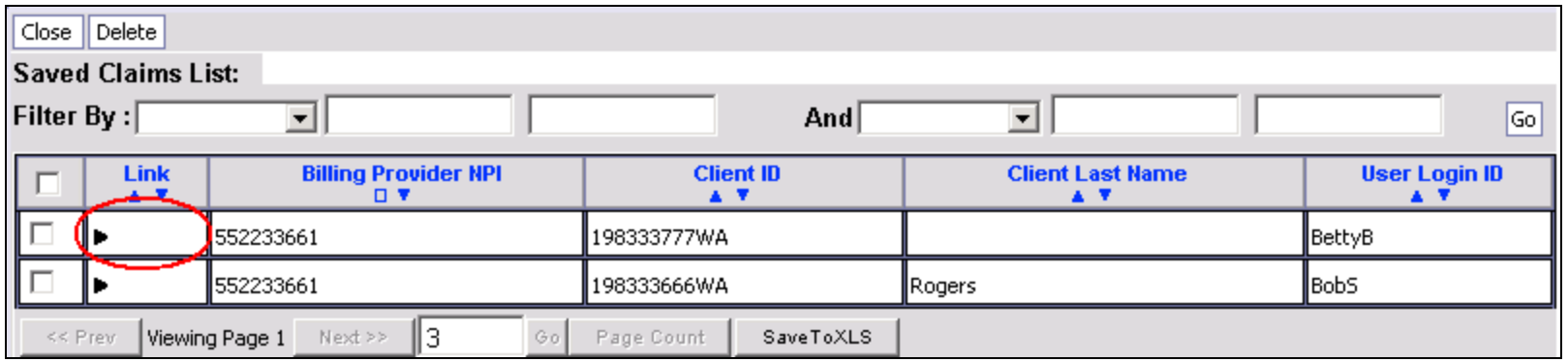
Retrieving a Saved Direct Data Entry Claim

- At the Provider Portal, click on the "Retrieve Saved Claims" hyperlink



Retrieving a Saved Direct Data Entry Claim

- ProviderOne displays the Saved Claims List.
  - ✓ Click on the **"Link"** Icon to retrieve a claim.

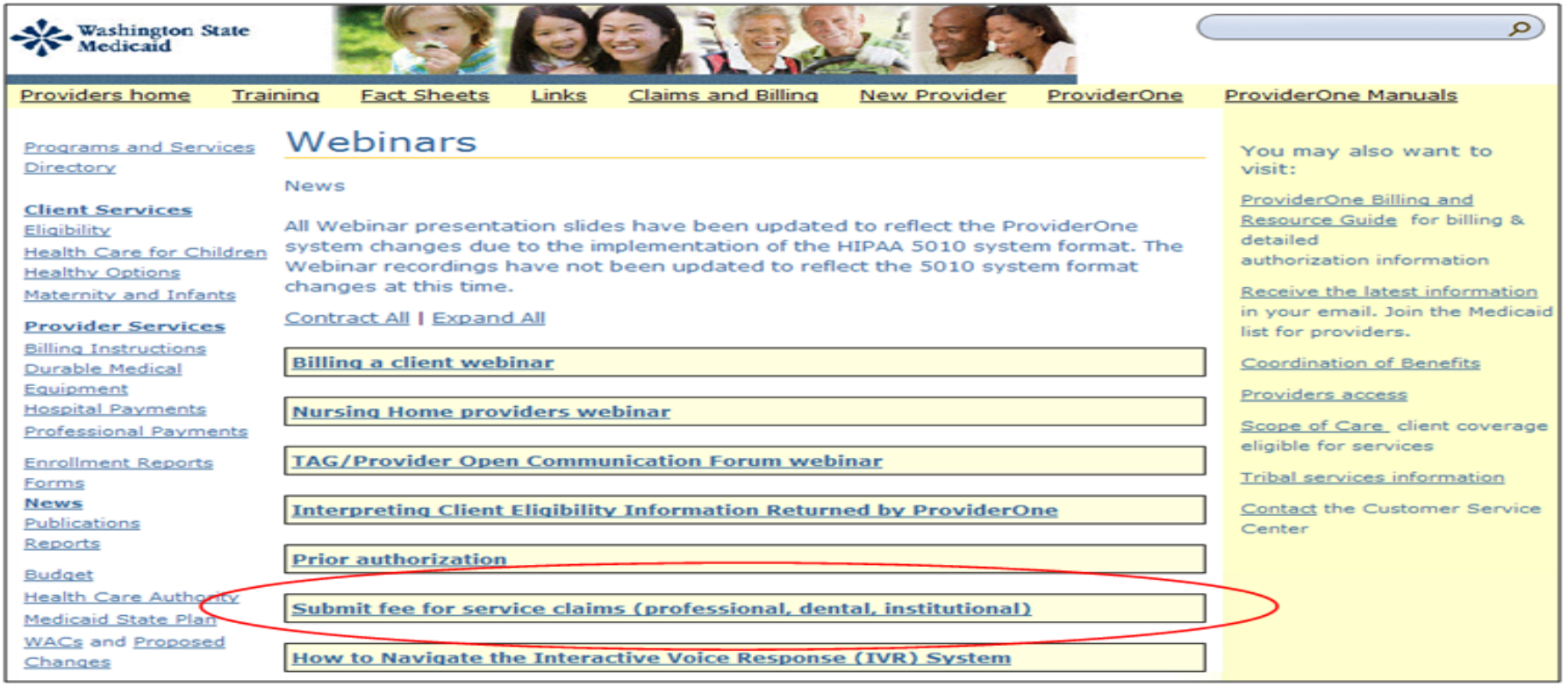


- The system loads the saved claim in the correct DDE claim form screen. Continue to enter data, then submit the claim.

- Once a saved claim has been retrieved and submitted, it will be removed from the Saved Claim List.

Direct Data Entry Claims (DDE)

- Online step by step instructions for all claim types at: http://hrsa.dshs.wa.gov/provider/webinar.shtml



Medicare Crossover

Medicare Crossover Claims

Learning Objectives

- After this training, you will be able to:
  - ✓ Verify if a Client has Medicare and determine the type of coverage they have
  - ✓ Bill Medicare crossovers on professional and institutional claim formats electronically
  - ✓ Better understand the Payment Methodology for Medicare parts A, B, and C
  - ✓ Learn tips on billing crossovers successfully

Common Terminology

- Coinsurance
  - ✓ An amount a Medicare client may be required to pay as their share of the cost for services.
- Deductible
  - ✓ The amount for which a beneficiary is responsible before Medicare starts paying.
- Capitated Copayment
  - ✓ A predetermined set dollar amount a Medicare client may be required to pay as their share of the cost for services.
- Non-Capitated Copayment
  - ✓ An amount a Medicare client may be required to pay as their share of the cost for services.

Overview – Medicare Crossover

- There are 4 types of Medicare coverage:
  - ✓ Medicare Part A Inpatient hospital services
  - ✓ Medicare Part B Covers professional and vendor services
  - ✓ Medicare Part C Managed Care version of Medicare, a Medicare Advantage Plan
  - ✓ Medicare Part D Covers prescription drugs
- When is a claim a Medicare Crossover claim?
  - ✓ If Medicare pays or applies to the deductible, the claim billed to HCA is a crossover.
  - ✓ The general rule is to bill the Agency after Medicare on the same claim form billed to Medicare.
  - ✓ The Agency is not paying Part D co-pays. (Part D is not covered in this presentation)

Overview - Medicare Crossovers

- When is a claim **NOT** a crossover claim?
  - ✓ Claims (services) denied by Medicare when billed to us are not crossover claims.
  - ✓ We still require the Medicare EOB to demonstrate non-payment.
- Sometimes Medicare does **NOT** forward claims automatically to the Agency
  - ✓ Can submit in Direct Data Entry or Electronically without the EOMB.
  - ✓ The Medicare Advantage Plans do not cross claim directly so they must be billed as crossover claims.

Overview - Medicare Crossovers

- If Medicare denies a Medical Assistance-covered service that requires Prior Authorization, the service still requires authorization
  - ✓ You may request it after the service is provided.
  - ✓ The Agency waives the "prior" requirement in this circumstance.

Medicare Eligibility

- Eligibility checks may show Medicare as:
  - ✓ QMB – Medicare Only (Qualified Medicare Beneficiary)
    - This program pays for Medicare premiums and may pay deductibles, coinsurance, and copayments according to Medicaid rules.
  - ✓ CNP-QMB (Categorically Needy Program – Qualified Medicare Beneficiary)
    - Client has full Medicaid as well as QMB benefits.

Medicare Eligibility

- Programs that HCA would not consider for secondary payment after Medicare
  - ✓ SLMB (Special Low Income Medicare Beneficiary)
    - This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.
  - ✓ QI-1 (Qualified Individual 1)
    - This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.
  - ✓ QDWI (Qualified Disabled Working Individual) –
    - This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.

Medicare Eligibility

- Determine Medicare eligibility using ProviderOne

Medicare Eligibility Information

Service Type Code	Insurance Type Code	Eligibility Start Date	Eligibility End Date
30: Health Benefit Plan Coverage	MA: Medicare Part A	01/01/2004	12/31/2999
30: Health Benefit Plan Coverage	MB: Medicare Part B	01/01/2004	12/31/2999

  - ✓ The Medicare HIC number is listed under the "Client Demographic Section"

- Medicare Part C information (if loaded) is located under the COB section

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	RXAMERICA (800) 429-6686	S5644		Med Part D			01/01/2008	12/31/201
30: Health Benefit Plan Coverage	C1: Commercial	STERLING LIFE INSURANCE COMPANY (360) 647-9080	H5006		Med Part C			03/01/2006	12/31/201

Washington State Health Care Authority
Medicaid

The Medicare Crossover Process

Client is Eligible for Medicare and Medical Assistance

Yes

Bill Medicare

(*You must accept Medicare Assignment*)

Medicare allows the service?

No

Your claim is not a crossover. Bill HCA within 365 days of Date of Service and submit the EOMB with your claim.

Yes

Was the claim forwarded to HCA by Medicare?

No

Submit your crossover claim to HCA within 6 months of the Medicare processing date. Make sure to use the same claim type you used to bill Medicare.

YES -HCA processes the claim.

Washington State Health Care Authority

Medicare Billing Part B

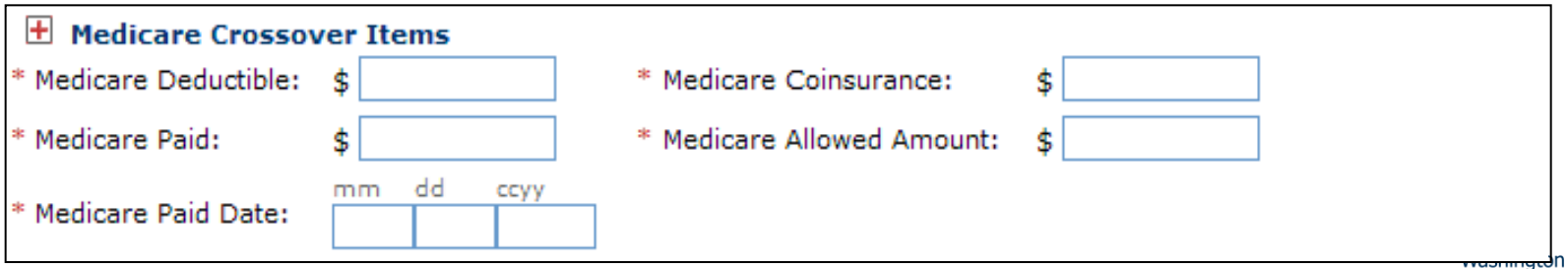
Medicare Billing – Part B

- CMS-1500, 837P
  - ✓ If Medicare has paid all lines on your claim and did not forward the claim to WA Medicaid, submit the crossover claim to the Agency.
  - ✓ If Medicare has allowed and denied service lines on your claim:
    - You will need to submit **TWO** claims to the Agency;
      - One crossover claim for services Medicare paid and;
      - One professional claim for services Medicare denied.

Medicare Billing – Part B

- Bill the Agency using the same service codes and billed amounts sent to Medicare.
- Medicare and Medicare Advantage Plans are Medicare
  - ✓ HCA does not consider Medicare as insurance
- When submitting via Direct Data Entry (DDE)
  - ✓ Click the Radio button **"YES"** to indicate this claim is a crossover

  - ✓ Additional data boxes open to be filled in as required at claim level.



Medicare Billing – Part B

- The rest of claim information is filled out as normal down to the service line information. The Medicare line data must be entered here now.

- **Note:** Entering the line level Medicare information is required if the previous question concerning Medicare Crossovers was answered yes. The line level Medicare payment data sum must match the claim level Medicare payment data entered.

Medicare Crossover Items

* Medicare Deductible:	$	* Medicare Coinsurance:	$
* Medicare Paid:	$	* Medicare Allowed Amount:	$
* Medicare Paid Date:	mm dd ccyy		

- No EOB is required with the DDE crossover claim.

Medicare Billing – Part B

- HIPAA batch 837P:

Medicare Information

- Loop 2320 – Other Subscriber Information
  - ✓ SBR09 = **MB**

Medicare Payment Information

- Loop 2430 – Coordination Of Benefits
  - ✓ SVD02 = Medicare Paid Amount
  - ✓ CAS01 = PR-Patient Responsibility
  - ✓ CAS02 = 1-Deductible Amount
  - ✓ CAS02 = 2-Coinsurance
  - ✓ DTP03 = Medicare Paid Date (CCYYMMDD)

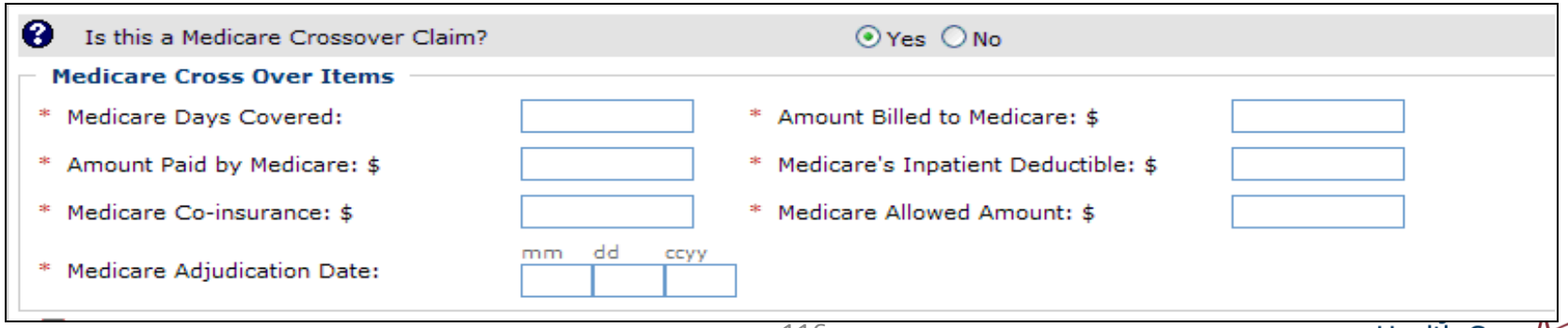
Medicare Billing Part A

Medicare Billing – Part A

- UB-04, 837I
  - ✓ If you bill Medicare using the UB-04 claim format, you would bill the Agency using the same claim format.
  - ✓ Include the same services and billed amounts you sent to Medicare.

RHC note: One date of service per claim form

- Submit DDE crossover claims in ProviderOne
  - ✓ Click Radio button "yes" to indicate claim is a crossover then fill in the data boxes.



Medicare Billing – Part A

- HIPAA batch 837I:

Medicare Information

- ✓ Loop 2320 – Other Subscriber Information
  - SBR09 – **MA** or **MB**

Medicare Payment Information

- ✓ Loop 2320 – Claim Level Adjustment
  - CAS01 = PR-Patient Responsibility
  - CAS02 = 1-Deductible Amount
  - CAS02 = 2-Co-Insurance
- ✓ Loop 2320 – Coordination Of Benefits
  - AMT01 = D-Medicare Amount Paid
- ✓ Loop 2330B – Claim Process Date
  - DTP03 = Medicare Paid Date (CCYYMMDD)

Medicare Billing – Part A

- HIPAA batch 837I:

Medicare Payment Information (continued)

- ✓ Loop 2430 = Claim Level Adjustment
  - SVD02 = Medicare Paid Amount
  - CAS01 = PR-Patient Responsibility
  - CAS02 = 1-Deductible Amount
  - CAS02 = 2-Co-Insurance
  - DTP03 = Medicare Paid Date (CCYYMMDD)

Medicare Billing Part C

Medicare Billing – Part C

- Some clients have elected to enroll in a Medicare HMO plan called a Medicare Advantage Plan (Part C)
  - ✓ Providers are required to bill the Med Advantage Plans.
  - ✓ Follow the billing guidelines established by the Plans.
- After the Med Advantage plan pays the claim, submit the crossover claim to Medical Assistance.
  - ✓ Bill Medical Assistance on the same claim format.
  - ✓ Make sure the services and billed amounts match what was billed to the Medicare Advantage plan.
  - ✓ No EOMB needed for DDE (it is a crossover claim).
  - ✓ The Agency must receive the Medicare Advantage claim within 6 months of the Medicare Advantage payment date.

Medicare Billing – Part C

- If there is a Capitated Copayment due on claim:
  - ✓ These claims are still billed as crossover claims.
  - ✓ Capitated Copayment crossover claims do not require an EOB.
  - ✓ Comments are no longer required on the claim.
  - ✓ Bill just the Capitated Copayment.
  - ✓ Questions? Detailed instructions for billing are located on page 99 of the *ProviderOne Billing and Resource Guide* located at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html

Medicare Billing – Part C

- If there is coinsurance, a deductible, or a Non-Capitated Copayment due on a claim.
  - ✓ These claims are billed as crossover claims.
  - ✓ DDE and Electronic crossover claims do not require the EOB with the claim.
  - ✓ Comments are no longer required on the claim.
  - ✓ Questions? Detailed instructions for billing are located on page 99 of the *ProviderOne Billing and Resource Guide* located at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html

Medicare Billing – Part C

- If the Medicare Advantage Plan does not cover the service
  - ✓ Bill the Agency for the services if the client has Medicaid medical coverage.
  - ✓ The Agency does not pay for the service if the client is only QMB eligible.
  - ✓ Discrepancies, disputes, protests should be directed to the Medicare Advantage plan.
  - ✓ If the Plan adjusts your payment and the crossover claim has been paid, you should adjust the crossover claim.
  - ✓ Submit a new crossover claim if the original claim was denied and the Plan adjustment could result in a payment.

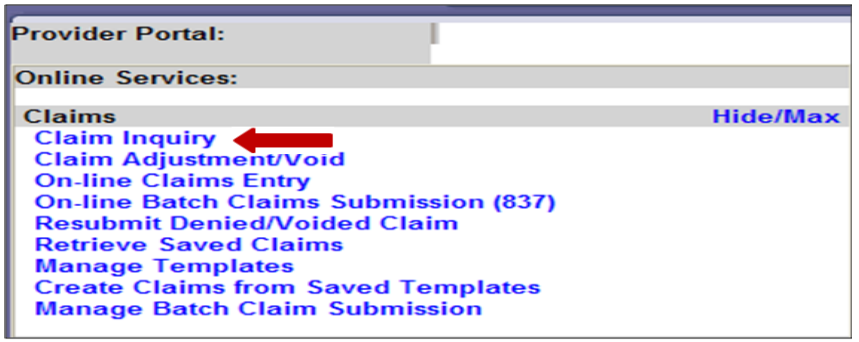
Tips on Billing Crossovers

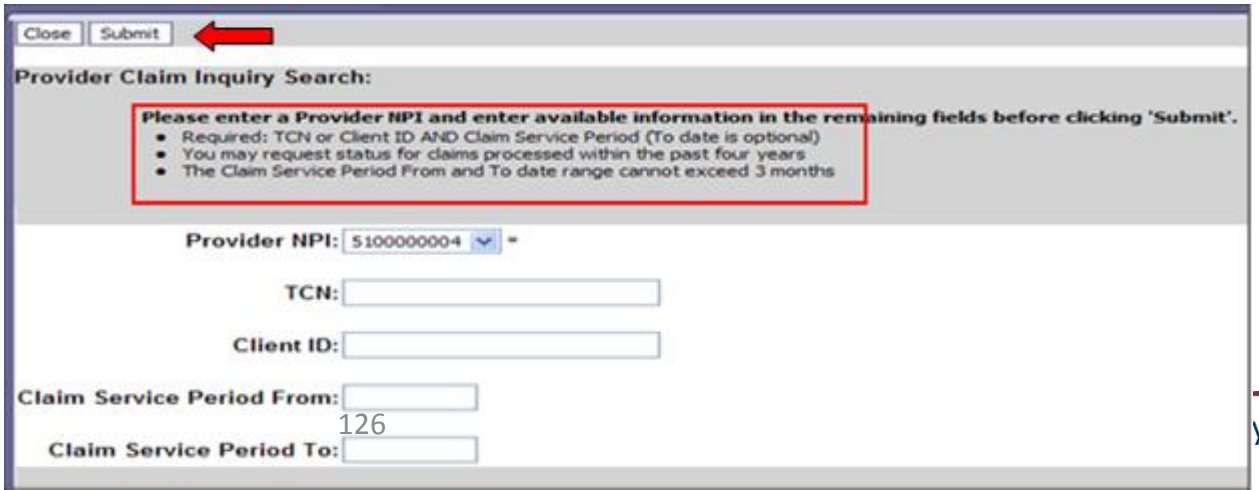
- Bill your taxonomy code(s) to Medicare the same as you bill your taxonomy code(s) to Medicaid.
- There will be a claim denial due to:
  - ✓ Billing Medicare with an NPI not been reported to the Agency.
    - The Agency will not be able to identify the provider when these claims are forwarded by Medicare.
  - ✓ Billing a paper crossover claim to the Agency without a copy of the Medicare EOB attached.
  - ✓ The claim format billed to Medicare does not match the claim format billed to Medical Assistance.
  - ✓ The coding and dollar amount billed do not match (paper claims).
  - ✓ Failure to fill data in all required fields on the DDE crossover screen.

Claim Inquiry

Claim Inquiry

- How do I find claims in ProviderOne?
  - ✓ Choose the **"Claim Inquiry"** Option from the Provider Portal
  - ✓ Enter search data then click on the **"Submit"** button.





Claim Inquiry

- Claim Transaction Control Number (TCN's) returned
  - ✓ Click on the **"TCN"** number to view the claim data.
  - ✓ Denied claims will show the denial codes.
  - ✓ Easiest way to find a timely TCN number for re-bills.

Claim Inquiry Providers List:

	TCN	Date of Service	Claim Status	Claim Charged Amount
☐	1030200005720000	10/14/2010	0: Cannot provide further status electronically.	$888.00
☐	1101100018152000	10/14/2010	0: Cannot provide further status electronically.	$888.00
☐	1105400007698000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1106100031712000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1106600001668000	10/14/2010	1: For more detailed information, see remittance advice.	$750.00
☐	1106600003011000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1107500035007000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1108200019887000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1113600005638000	10/14/2010	0: Cannot provide further status electronically.	$750.00
☐	1114400017409000	10/14/2010	1: For more detailed information, see remittance advice.	$750.00

<< Prev Viewing Page 1 Next >> 2 Go Page Count = 2 SaveToXLS

Why can't I pull up my claim?!

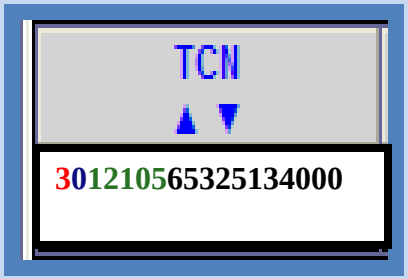
- There are many reasons why you might not be able to retrieve a claim (for any system functions).
  - ✓ It has been Adjusted, you can't retrieve a claim that has already been Adjusted.
  - ✓ It has been replaced by another claim.
  - ✓ It hasn't finished processing.
  - ✓ It was billed under a different domain.
  - ✓ You could be using the wrong profile.
  - ✓ You submitted by batch with more than 1 NDC on a claim line.
  - ✓ Trying to do a Resubmit on a paid claim or an Adjustment to a denied claim.
  - ✓ Claims billed with an NPI not reported in ProviderOne.
  - ✓ Claims billed with an ID only rendering provider NPI number as the pay-to provider.

Billing Timely

- What are the Agency's timeliness guidelines?
  - ✓ The initial billing must occur within 365 days from the date of service on the claim.
  - ✓ Providers are allowed 2 years in total to get a claim paid or adjusted.
  - ✓ For Delayed Certification client eligibility the Agency allows 12 months from the Delayed Cert date to bill.
  - ✓ Recoupment's from other payers-timeliness starts from the date of the recoupment, not the date of service.
  - ✓ Trimester care-determined from the Expected Date of Delivery (EDD), EDD must be noted on the claim.
  - ✓ The Agency uses the Julian calendar for dates.
  - ✓ Crossover and Pharmacy claims have different timeliness guidelines.

What is a TCN?

TCN=Transaction Control Number



18 digit number that ProviderOne assigns to each claim received for processing. TCN numbers are never repeated.

How do I read a TCN?

1st digit-Claim Medium Indicator	2nd digit-Type of claim	3rd thru 7th digits-date claim was received
• 1-paper • 2-Direct Data Entry • 3-electronic, batch submission • 4-system generated (Credits/Adjustment)	• 0-Medical • 2-Crossover or Medical	• 3rd and 4th digits are the year • 5th, 6th and 7th digits are the day it was received

Example TCN:30121046532513400 0

3-electronic submission via batch

0-medical claim

12-year claim was received, 2012

104-day claim was received, April 13th

How do I prove timeliness?

- HIPAA batch transaction
  - ✓ Electronic submission-Professional, Institutional & Dental
    - Enter the timely TCN in the claim note, Loop 2300, segment NTE02=TCN*

*837I institutional has 2 NTE segments, we capture information from either segment.

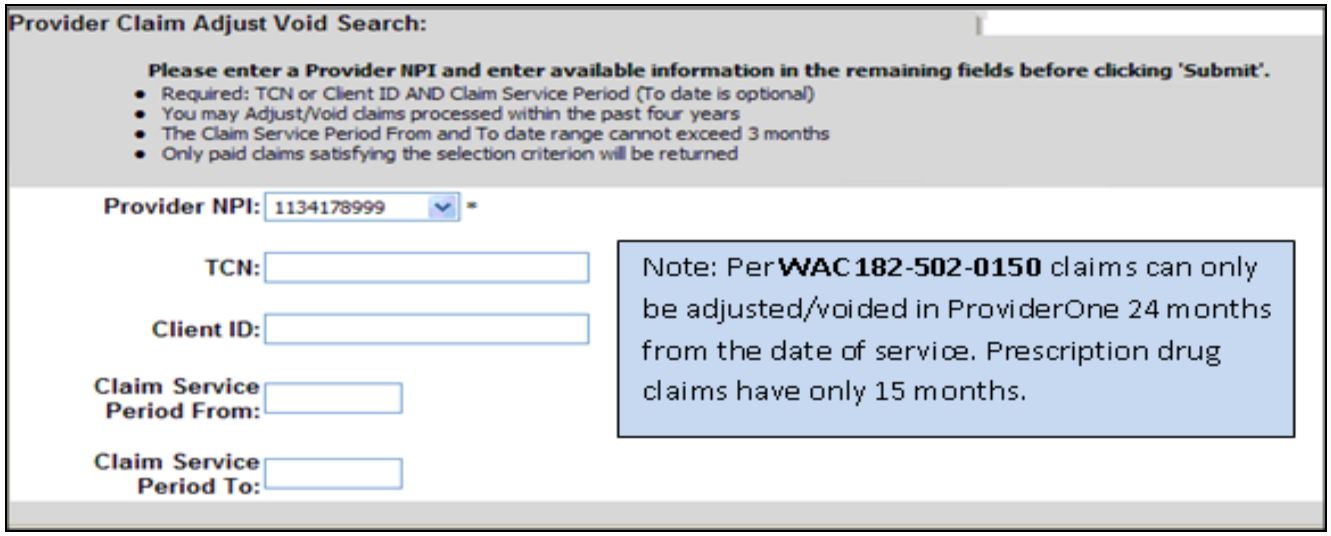
- Direct Data Entry (DDE) Claims
  - ✓Resubmit Original Denied/Voided Claim; or
  - ✓Enter timely TCN in the "Claim Note"
  - ✓Enter recoupment statement in "Claim Note"
    "Recouped for SSI, 00/00/00"
  - ✓Enter EDD date in "Claim Note"

How do I prove timeliness?

- Paper billing-CMS-1500
  - ✓ Enter timely TCN in box 22
  - ✓ Enter the recoupment date in box 19
  - ✓ Enter the EDD date in box 19
- Paper billing-UB04
  - ✓ Enter timely TCN in box 64 a-c
- Paper billing-ADA
  - ✓ Enter timely TCN in box 35

Adjust/Void a Paid Claim

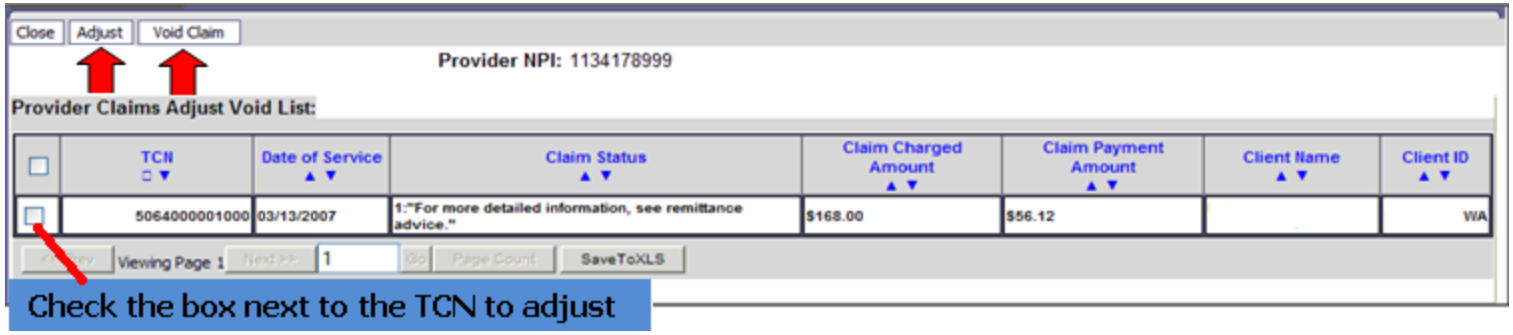
- Select "Claim Adjustment/Void" from the Provider Portal.



- Enter the TCN number if known; or
- Enter the Client ID, and the From-To date of service.

Adjust/Void a Paid Claim

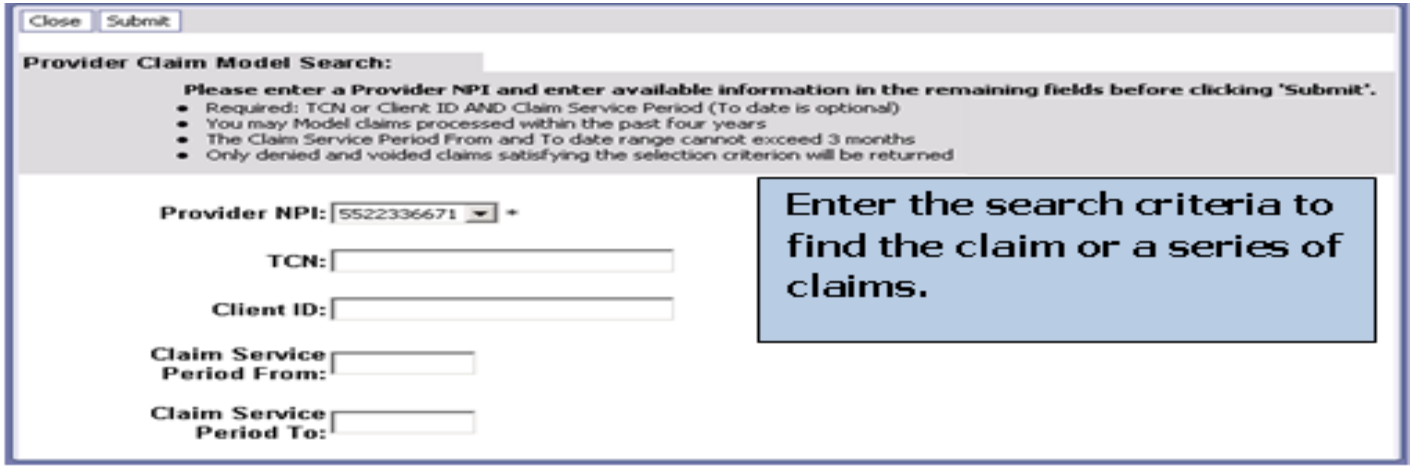
- The system will display the paid claim(s) based on the search criteria.



- Check the box of the TCN to adjust/void.
- ProviderOne loads the DDE screen with the claim data.
  - ✓ Update the claim information to adjust, then submit.
  - ✓ Claim data can not be changed when doing a void, just submit the void.

Resubmit a Denied Claim

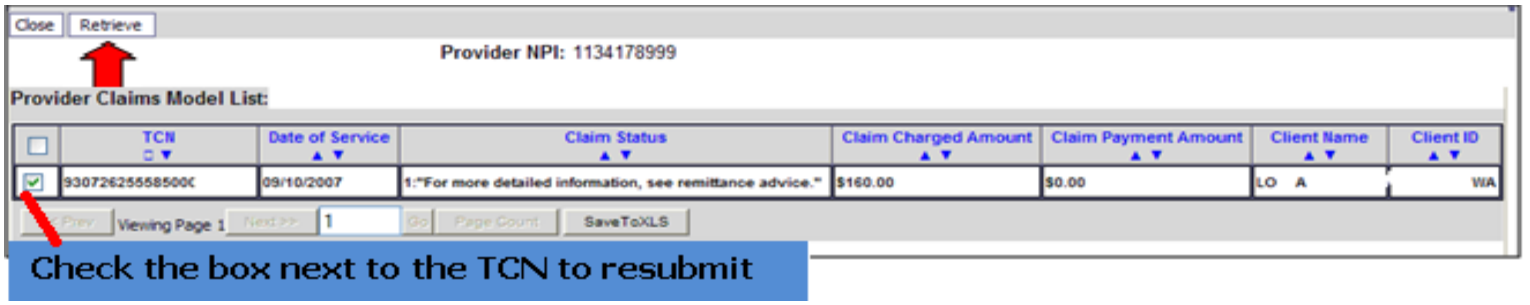
- Select "Resubmit Denied/Voided Claim" from the Provide Portal.



- A TCN will bring up only one claim.
- Enter the Client ID and the From-To dates of service to find all claims billed these dates.

Resubmit a Denied Claim

- The system will display the claim(s) based on the search criteria.

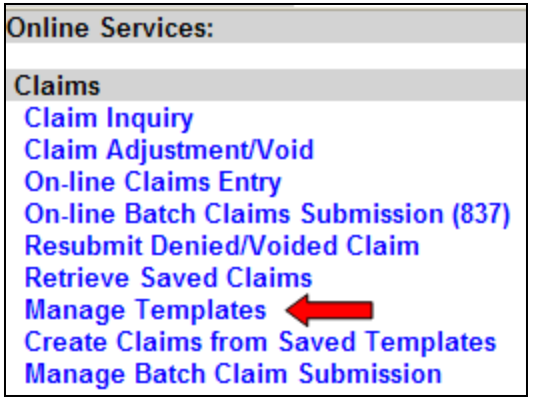


- Check the box of the TCN to resubmit.
- ProviderOne loads the DDE screen with the claim data.
  - ✓ Update the claim information that caused the claim to deny, then submit.

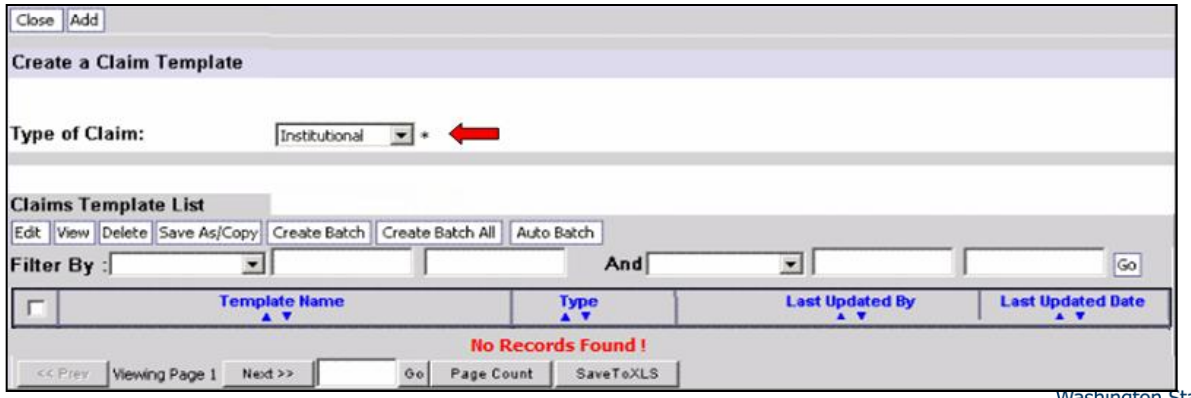
Creating a Claim Template

- ProviderOne allows creating and saving templates.

✓ Log into ProviderOne.
✓ Click on the **"Manage Templates"** hyperlink.

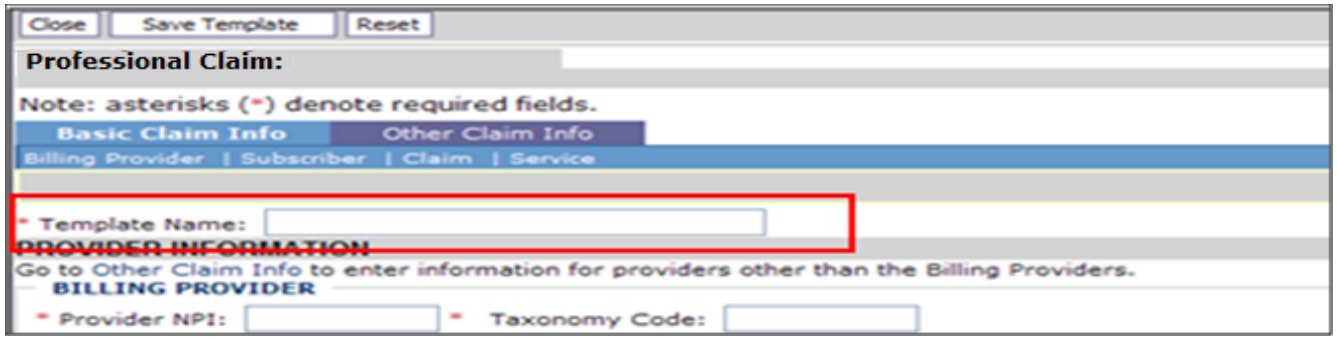


✓ At the Create a Claim Template and list screen, click the **"Type of Claim"** Option.



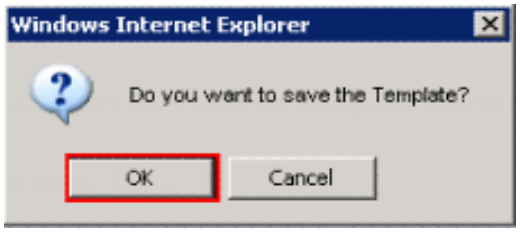
Creating a Claim Template

- Once a template type is picked the system opens in the DDE screen.



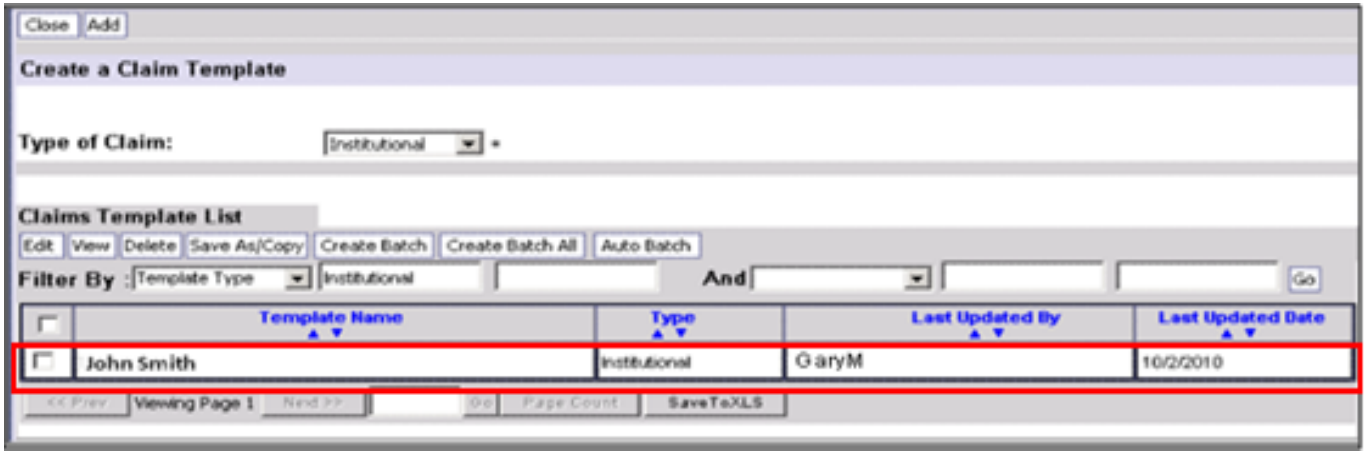
- Name the template then fill in as much data as wanted on the template.

- Click on the **"Save Template"** button and the system verifies you are saving the template. Click on the **"OK"** button to save template.



Creating a Claim Template

- After the template is saved it is listed on the **"Claim Template List"**.

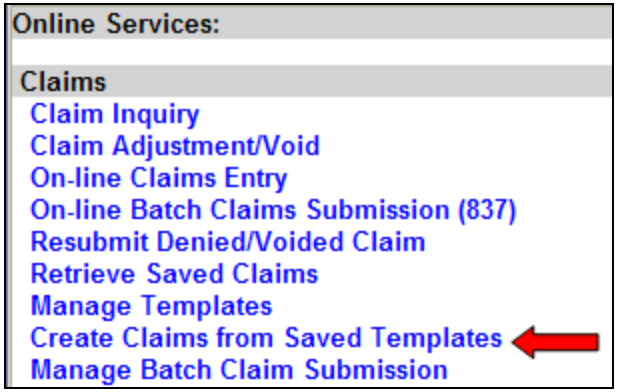


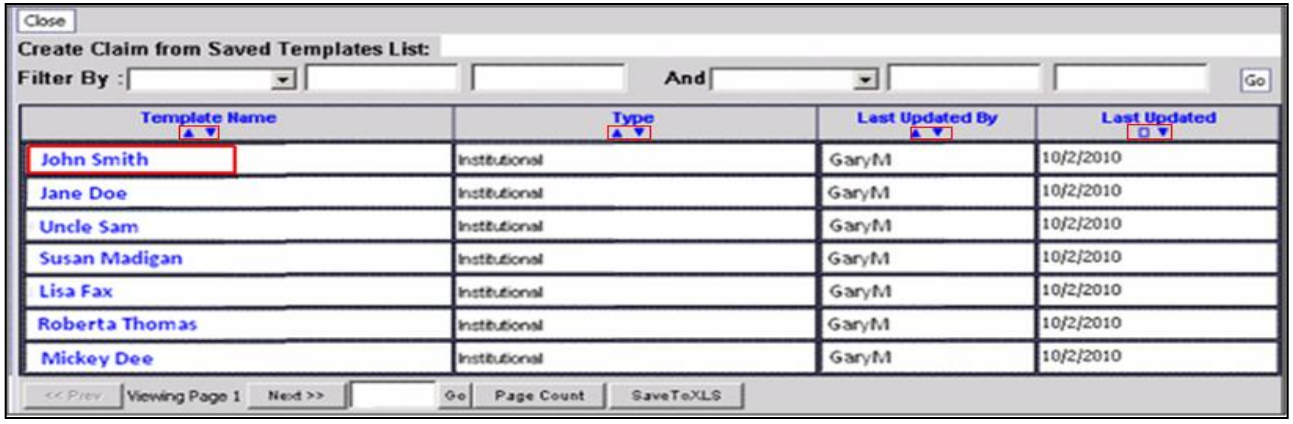
- Additional templates can be created:
  - ✓ Copying a template on the list; or
  - ✓ Creating another from scratch.
- Templates can be edited, viewed, and deleted.

Submitting a Template Claim

- Claims can be submitted from a Template.

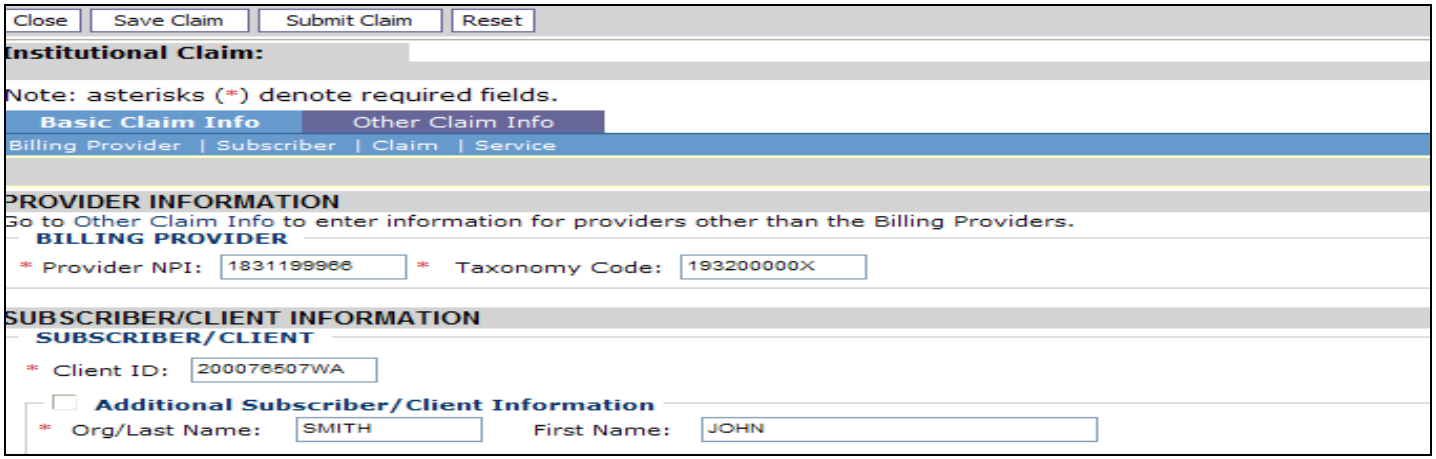
✓ Log into ProviderOne.
✓ Click on the **"Create Claims from Saved Templates"** hyperlink.
✓ At the Saved Template List find the template to use. (sort the list using the sort tools outlined)





Submitting a Template Claim

- Click on the Template name.
- The DDE screen is loaded with the template.



- Enter or update the data for claim submission then submit the claim.
- Batches of Template Claims can be created.
- See the Batch Template webinar at http://hrsa.dshs.wa.gov/provider/webinar.shtml.

Reading the Remittance Advice (RA)

Recoups/Adjustments

Reading the Remittance Advice (RA)

- How do I retrieve the PDF file for the RA?
  - ✓ Log into ProviderOne with a Claims/Payment Status Checker, Claims Submitter, or Super User profile.

✓ At the Portal click on the hyperlink **"View Payment"**.

✓ The system should open your list of RAs.

RA/ETRR Number	Check Number	Check/ETRR Date	RA Date	Claim Count	Charges	Payment Amount	Adjusted Amount	Download
2444447	000777	02/23/2012	02/24/2012	1428	$513,899.73	$62,865.54	$408,607.26	
2443392	000778	02/16/2012	02/17/2012	1538	$484,679.55	$63,959.26	$375,030.04	
2229984	004772	02/09/2012	02/10/2012	1384	$488,482.16	$80,452.68	$408,029.48	

✓ Click on the **"RA/ETRR Number"** in the first column to open the whole RA.

Reading the Remittance Advice (RA)

- The Remittance has several sections.
  - ✓ The first page contains the RA newsletter that could contain current provider alerts.

RA Number: 118021
Warrant/EFT #: 4387
Warrant/EFT Date: 08/09/2005

Prepared Date: 08/01/2005
RA Date: 08/08/2005

Warrant/EFT Amount: $2,149.75
Payment Method: Warrant
Page: 002

Claims Summary

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total TPL Amount	Total Client Resp. Amount	Total Paid
2250186000	Paid	$5418.00	$4638.00	$00.00	$00.00	$4584.25
2250186000	Denied	$11780.00	$00.00	$00.00	$00.00	$00.00
2250186000	Adjustments	$0.00	-$34.50	$00.00	$00.00	-$34.50
2250186000	Suspended	$156.00	$00.00	$00.00	$00.00	$00.00

Provider Adjustments

Billing Provider	FIN Invoice Number	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
2250186000	CM3876	System Initiated	WO: Overpayment Recovery	$1,200.00	$700.00	$500.00
2250186000	398744	HIPAA to System Initiated	LE: IRS Levy	$88,200.00	$1,700.00	$86,500.00

Total Adjustment Amount **$2,400.00**

  - ✓ Page 2 is the Claims Summary page (above).
  - ✓ The following sections could be Paid Claims, Denied Claims, Adjusted Claims, and In-Process Claims.

Reading the Remittance Advice (RA)

- The Summary Page shows:
  - ✓ Number of paid claims and total.
  - ✓ Number of denied claims.
  - ✓ Number of adjusted claims.
  - ✓ Provider Adjustments activity.

RA Number: 118021
Warrant/EFT #: 4387
Warrant/EFT Date: 08/09/2005

Prepared Date: 08/01/2005
RA Date: 08/08/2005

Warrant/EFT Amount: $2,149.75
Payment Method: Warrant
Page: 002

Claims Summary

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total TPL Amount	Total Client Resp. Amount	Total Paid
2250186000	Paid	$5418.00	$4638.00	$00.00	$00.00	$4584.25
2250186000	Denied	$11780.00	$00.00	$00.00	$00.00	$00.00
2250186000	Adjustments	$0.00	-$34.50	$00.00	$00.00	-$34.50
2250186000	Suspended	$156.00	$00.00	$00.00	$00.00	$00.00

Provider Adjustments

Billing Provider	FIN Invoice Number	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
2250186000	CM3876	System Initiated	WO: Overpayment Recovery	$1,200.00	$700.00	$500.00
2250186000	398744	HIPAA to System Initiated	LE: IRS Levy	$88,200.00	$1,700.00	$86,500.00

Total Adjustment Amount **$2,400.00**

Reading the Remittance Advice (RA)

- Provider Adjustments:
  - ✓ The number of claims being adjusted (credit) may exceed the Total Paid amount.
  - ✓ Credit balance adjustments are displayed on the right side of the summary page.

Provider Adjustments **Page 3**

Billing Provider	FIN Invoice Number	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
2250188000	[redacted]	Provider Initiated	CASH RECEIVED Invoice	$37.86	$0.00	$37.86
2250188000	[redacted]	Provider Initiated	CASH RECEIVED Invoice	$25.87	$0.00	$25.87
Total Adjustment Amount						

Reading the Remittance Advice (RA)

- Provider Adjustments:
  - ✓ These adjustment amounts can carry over on each weeks RA until reduced by the number of paid claims for that week.
  - ✓ Claims that caused these carry over adjustment amounts can be on previous RAs.
  - ✓ Credit balance RAs have a "check number" that looks like this: **JVAH0223344556677800**.
  - ✓ ProviderOne automatically sends credit balance amounts to our finance office after a certain time if the NPI number does not generate claim payments.

Reading the Remittance Advice (RA)

- EOB Codes
  - ✓ The Adjustment Reason Codes; and
  - ✓ The Remark Codes for denied claims & payment adjustments are located on the last page of the RA.

Adjustment Reason Codes / NCPDP Rejection Codes
119 : Benefit maximum for this time period or occurrence has been reached.
125 : Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
16 : Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
204 : This service/equipment/drug is not covered under the patient's current benefit plan
22 : This care may be covered by another payer per coordination of benefits.
24 : Charges are covered under a capitation agreement/managed care plan.
26 : Expenses incurred prior to coverage.
4 : The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
45 : Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
96 : Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
A1 : Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Remark Codes
M47 : Missing/incomplete/invalid internal or document control number.
MA04 : Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
N152 : Missing/incomplete/invalid replacement claim information.
N329 : Missing/incomplete/invalid patient birth date.
N345 : Date range not valid with units submitted.
N362 : The number of Days or Units of Service exceeds our acceptable maximum.
N428 : Not covered when performed in this place of service.

  - ✓ The complete list of Federal codes can be located on **http://www.wpc-edi.com/reference/**.

Authorizations

Authorizations

1. Complete Authorization Form 13-835
2. Submit Authorization Request to the Agency with Required Back-up
3. Check the Status of a Request
4. Send in Additional Documentation if Requested by the Agency

Authorizations (Step 1)

1. Complete Authorization Form 13-835
   a) To begin the authorization process providers need to complete HCA Form 13-835. ProviderOne can begin processing the authorization request once the Agency receives this form filled out correctly.
   b) Access the online authorization form 13-835 at http://hrsa.dshs.wa.gov/mpforms.shtml.

Step by step instructions: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide/PA_Chapter.pdf

Washington State Health Care Authority

General Information for Authorization

Org	1.	Service Type	2.
Client Information			
Name	3.	Client ID	4.
Living Arrangements	5.	Reference Auth #	6.
Provider Information			
Requesting NPI #	7.	Requesting Fax #	8.
Billing NPI #	9.	Name	10.
Referring NPI #	11.	Referring Fax #	12.
Service Start Date:	13.		14.
Service Request Information			
Description of service being requested: 15.		16.	17.
18. Serial / NEA#		19.	

20. Code Qualifier	21. National Code	22. Mod	23. # Units/Days Requested	24. $ Amount Requested	25. Part # (DME Only)	26. Tooth or Quad #

Medical Information			
Diagnosis Code	27.	Diagnosis name	28.
Place of service	29.		
30. Comments:			

http://hrsa.dshs.wa.gov/mpforms.shtml

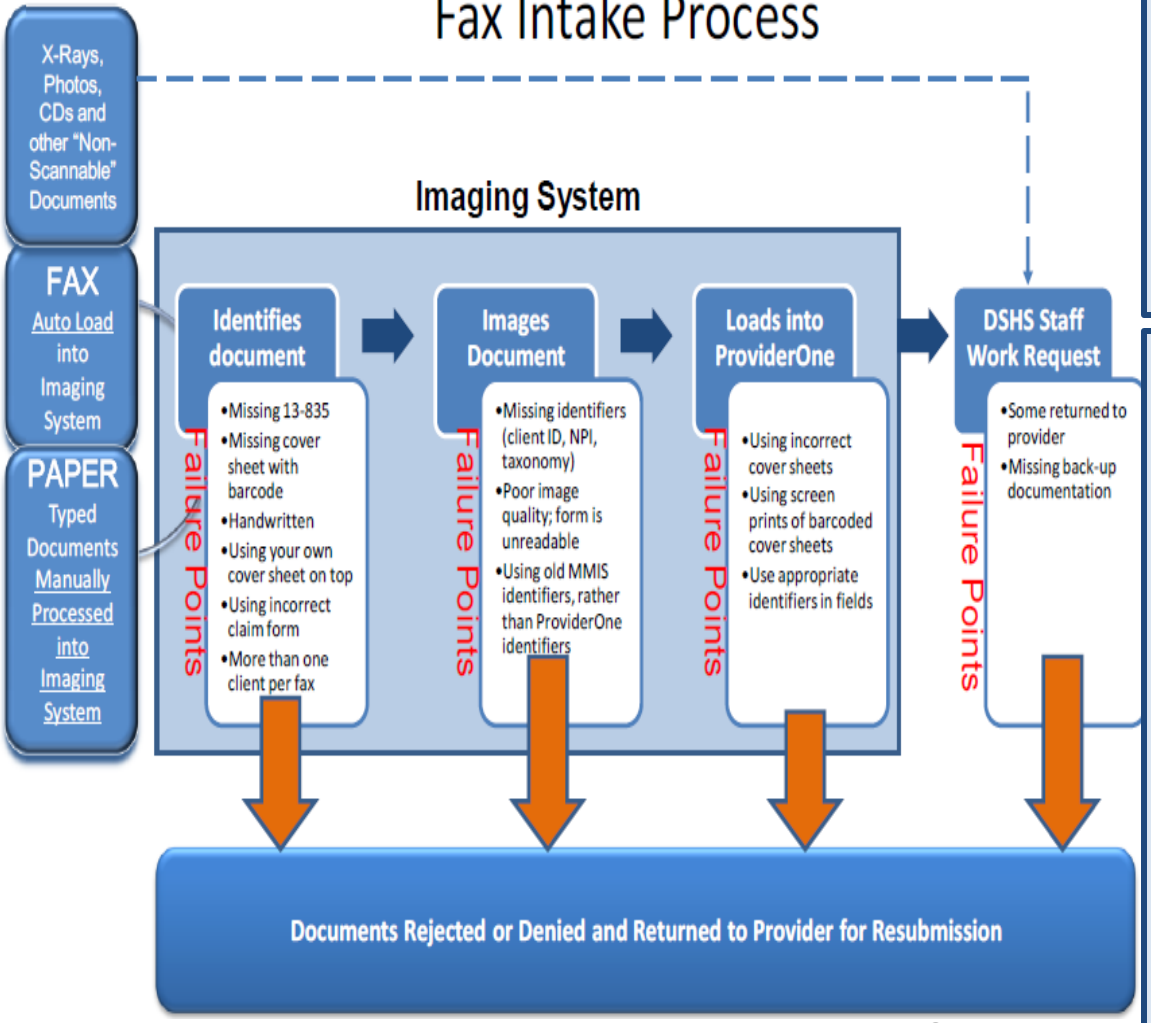
Please Fax this form and any supporting documents to 1-866-668-1214.

The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. HIPAA Compliance: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to see insurance payment, or to perform other specific health care operations.

HCA 13-835 (8/2011)

Authorizations (Step 2)

Fax Intake Process



2.Submit Authorization Request to the Agency with Required Back-up

a) By Fax
   a) 1-866-668-1214
   b) Form 13-835 must be first

b) By Mail
   a) Authorization Services Office
      PO Box 45535
      Olympia, WA 98504

Scan larger backup using *FastAttach*

For Dental Providers: (NEA)

Register with NEA by visiting www.nea-fast.com and entering "FastWDSHS" in the blue promotion code box.

Contact NEA at 800-782-5150 ext. 2 with any questions.

For Medical/DME Providers: (MEA)

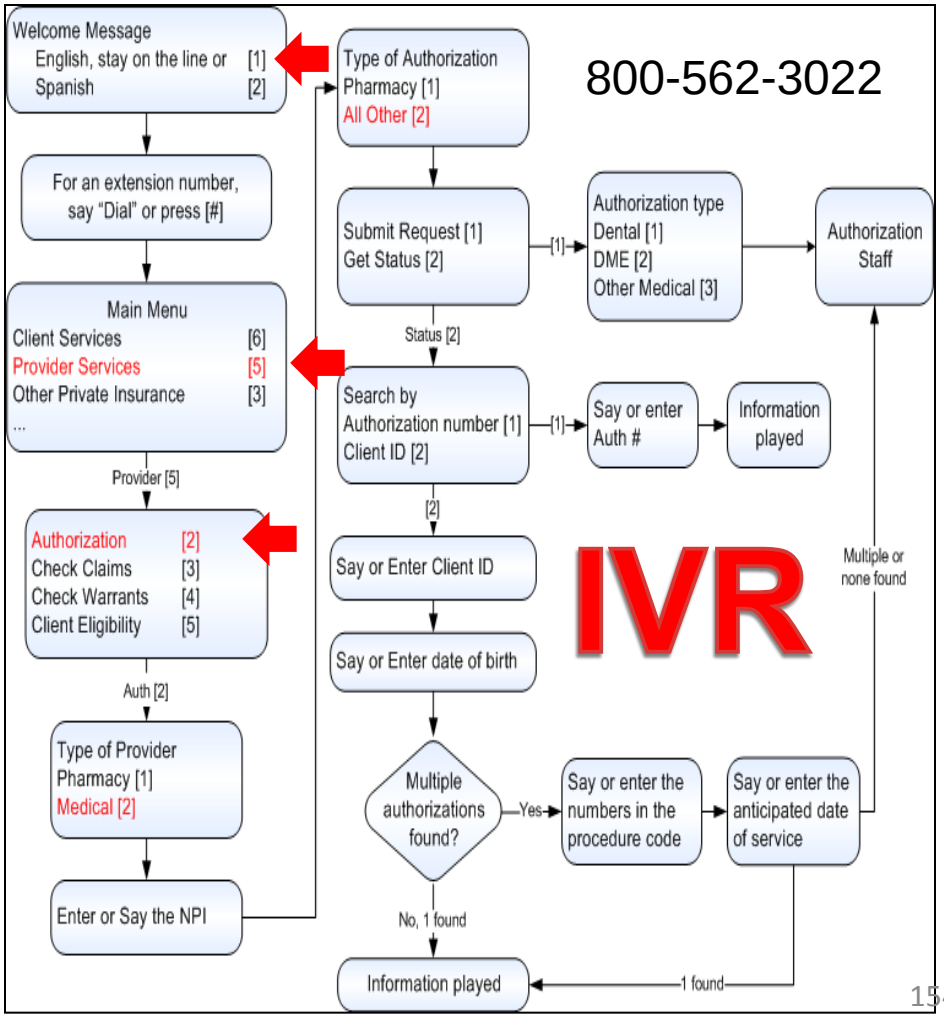
www.mea-fast.com

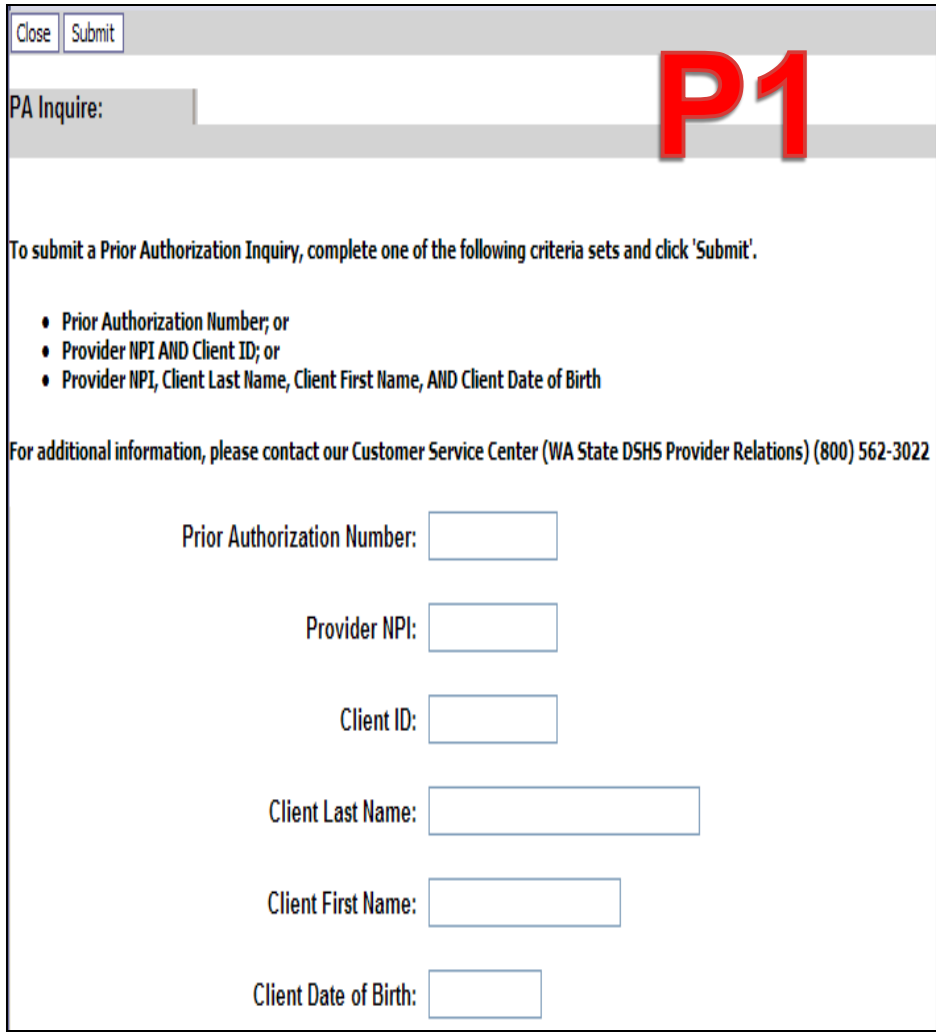
Phone 1-888-329-9988 extension 3.

Please identify your office as a participant in the Washington Department of Social and Health Services pilot.

Give the technician promotion code MEAFFL.

Check the Status of a Request (Step 3)





Check the Status of a Request (Step 3)

Close

PA Utilization:

Authorization #: 100000226
Client ID: 100149763WA
Service: Partial
Request Date: 5/9/2010
Service Start Date: 6/14/2010
Requestor ID: 1972676971

Authorization Status: Approved
Client Name:
Organization: PA - DENTAL
Last Updated Date: 6/14/2010
Service End Date: 6/14/2011
Requestor Name:

Line #	Modified Date	Servicing Provider ID	Code	Claim Type	Modifier1	ToothNum	ToothSurf	Quad	From Date	To Date	Request Amount	Request Units	Auth Amount	Auth Units	Used Amount	Used Units	Status
1	06/14/2010	1297174503	D5213	K-Dental Claim				01	06/14/2010	06/14/2010	0	1	0	1	0	0	Approved

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

Requested	This means the authorization has been requested and received.
In Review	This means the authorization is currently being reviewed.
Cancelled	This means the authorization request has been cancelled.
Pended	This means we have requested additional information from the provider in order to make a decision on the request.
Referred	This means the request has been forwarded to a second level reviewer.
Approved/Hold	This means the request has been approved, but additional information is necessary before the authorization will be released for billing.
Approved/Denied	This means the request has been partially approved and some services have been denied.
Rejected	This means the request was returned to the provider as incomplete.
Approved	This means the Agency has approved the request.
Denied	This means the Agency has denied the request.

The following statuses may be returned by IVR and ProviderOne

Authorization Step 4. Send in Additional Documentation if Requested by the Agency

a.) If you are mailing/faxing supporting documentation to an existing PA request, you will need to print and attach the DSHS cover sheet.

ProviderOne

PA Pend Forms Submission Cover Sheet

Authorization Reference # 123456789

(Please enter 9 digit numeric value.)

Print Cover Sheet | Clear Fields

Instructions will not appear on the printed coversheet

INSTRUCTIONS:
Click ENTER on your keyboard after typing the number in above.

Please use the **Print Cover Sheet** Button Above to print ONLY.

Use Only ADOBE Reader to generate this coversheet. Other readers will not generate the barcode correctly.

DO NOT USE FOR PHARMACY RELATED AUTHORIZATION REQUESTS!

Privacy Statement:
This material in this facsimile is intended only for the use of the individual who it is addressed and may contain information that is confidential, privileged and exempt from disclosure under applicable law.

HIPAA Compliance:
Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment to see insurance payment or to perform other specific health care operations.

FAX to : 1-866-668-1214.

THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET.

Cover Sheets can be located at:
http://hrsa.dshs.wa.gov/download/document_submission_cover_sheets.html

Expedited Prior Authorization (EPA)

1
- The Agency waives PA requirement for certain services
- Check the program-specific billing instructions

2
- Meet the administrative requirements (e.g., eligibility, claim timelines, third-party insurance, etc.)
- Check the fee schedule for the indication “EPA”

3
- Meet EPA Guidelines
  - Medical Justification (criteria)
  - Documentation
  - EPA criteria must be met

First 5 or 6 digits

Create **9** digit EPA number

870000_ _ _

Last 3 or 4 digits

Find your code assigned to the DX condition, procedure, or services

Enter EPA number on you claim form in the *authorization number field*

EPA Code	Service Name	CPT/HCPCS/Dx Code	Criteria
1302	Hysterectomies for Cancer	58150, 58152, 58180, 58200, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58545, 58546, 58550, 58552, 58553, 58554, 58570, 58571	**Client must have a diagnosis of cancer requiring a hysterectomy as part of the treatment plan**** **ICD 9 Dx codes: 179, 182.0, 182.1, 182.8, 183-183.9, 184-184.9. 198.6, 198.82, V10.4-V10.44**

EPA number for my client who meets the above criteria, and the procedure code to the left:

870001302

Qualis Authorization Process

- Register with Qualis Health's iEXCHANGE

Check Billing Instructions

Services Requiring Qualis Review

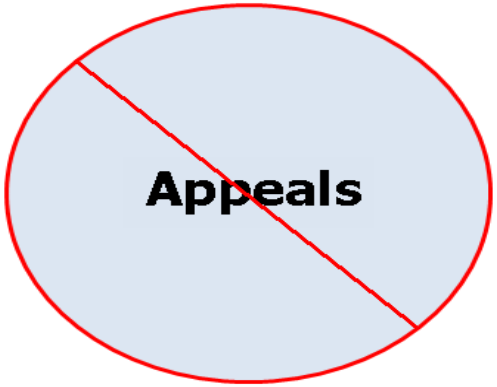
- Advanced Imaging
  - Q&A
- Surgical Reviews
  - Q&A

Provider Education

Webinars, guides, and FAQS

Claim Appeals

Claim Appeals



- We don't have an "appeal process" for denied claims.
- Fix the claim error causing claim denial and resubmit the claim.
- If you think the claim(s) were denied in error submit a work ticket online at https://fortress.wa.gov/dshs/p1contactus/.
- Work tickets average 15 days to process. Complex tickets can take longer.

Pharmacy

Pharmacy

- Pharmacies bill most of their claims in the Point of Sale (POS) system.
- Pharmacies can also bill for:
  - ✓ Compliance Packaging
  - ✓ Clozaril/Clozapine case coordination
  - ✓ Emergency Contraception Counseling
  - ✓ Vaccines & Administration fees
  - ✓ Influenza & Pneumonia Admin
  - ✓ Pre-filling Syringes
- Pharmacies can bill for Durable and Non-durable supplies.
- Bill supplies on a CMS-1500 claim, E- claim as an 837P claim or a professional DDE claim.
- Bill Medicare/Med Advantage secondary as crossover claims.

Swing Bed

Swing Bed

- What is a Swing Bed?
  - ✓ Acute care hospital bed.
  - ✓ Certified by Medicare to provide acute or long term care.

- How does a client become placed in a Swing Bed?
  - ✓ Assessed eligible for long term care.
  - ✓ Must be Medicaid eligible and have an award letter for LTC.
  - ✓ Can stay in a LTC Swing Bed as long as financial and functional eligibility continues.

Swing Bed

- Provider bills for a Medicaid eligible patient in a Swing Bed:
  - ✓ Bill Medicaid a Nursing Home claim using a class code of 26 for the Per Diem room and board.
  - ✓ Bill Medicaid any pharmacy needs using the Point of Sale (POS) Pharmacy billing system.
  - ✓ Bill Medicaid an outpatient claim for any covered services not included in the Swing Bed Daily Rate (x-rays, lab, ER visit etc).
  - ✓ Bill other services and supplies not included in the Swing Bed Daily Rate.

Spenddown

What is a Spenddown?

- An expense or portion of an expense which has been determined by the Agency to be a client liability.
- Expenses which have been assigned to meet a client liability are not reimbursed by the Agency.
- Spenddown liability is deducted from any payment due the provider.
- See WAC 388-519 for complete details.

Why does the client have a Spenddown?

- Applicant applies for the MN (Medically Needy Program).
  - ✓ Has income above MN limits for medical benefits.
  - ✓ Required to spend down excess income.
- Applicant spends down excess income by incurring medical bills.
- Client becomes eligible for Medicaid medical benefits once incurred medical bills equal the spenddown amount.

How does a Provider know if a Client has a Spenddown Liability?

- Review the client eligibility screen in ProviderOne.
  - ✓ Benefit inquiry indicates "Pending Spenddown, No Medical."
  - ✓ Spenddown balance will be displayed.
- Ask the Client for a copy of their **"award"** letter.
  - ✓ Identifies the medical bills.
  - ✓ Indicates dollar amounts client must pay.
- Call the spenddown customer service center at 1-800-394-4571.

How does a Provider know if a Client has a Spenddown Liability?

- The client benefit inquiry indicating **"Pending Spenddown – No Medical"** looks like this:

Client Eligibility Spans

Service Type Code	Insurance Type Code	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group
30: Health Benefit Plan Coverage	MC: Medicaid	Pending Spenddown - No Medical	08/01/2011	12/31/2999	S99

What is the Spenddown amount?

- The same eligibility check indicates the spenddown amount:

Spenddown Information Base Period - Start: 08/01/2011 End: 01/31/2012

Total Spenddown	Spenddown Liability	Remaining Spenddown	EMER Liability	Remaining EMER	Spenddown Status	Update Date	Spenddown Start
2022.00	2022.00	2022.00	0.00	0.00	Pending	08/09/2011	08/01/2011

- The clients **"award"** letter indicates who the client pays.
- Contact the spenddown customer service center at 1-800-394-4571

When does a provider report the Spenddown amount on a claim?

- All providers must verify if the client has a spenddown if:
  - ✓ The client is on the LCP-MNP program.
  - ✓ The clients ACES Coverage Group Code ends with **"99"**.

Eligibility Start Date	Eligibility End Date	ACES Coverage Group
08/01/2011	12/31/2999	S99

✓ The claim DOS is the same as the client eligibility begin date**.**

✓ Call the spenddown customer service center at 1-800-394-4571.

When does a provider report the Spenddown amount on a claim?

- The agency checks the eligibility system (ACES) to see if the claim applies to the spenddown.
  - ✓ If claim applies and no spenddown is reported then the claim is denied.
  - ✓ If claim applies, spenddown must be reported accurately or the claim is denied.
  - ✓ If claim applies, spenddown is subtracted from service allowable and provider may be paid any difference.

What if the client has Medicare Primary and a Spenddown?

- QMB client eligibility
  - ✓ May have two active coverage segments at the same time.
    - The first segment is their QMB with the dates of coverage.
    - Second segment may be the **"Pending Spenddown"** with overlapping dates with the QMB segment.
  - ✓ Bill Medicare, then Medicaid as a crossover:
    - Medicaid may pay the crossover (depends on the Medicare paid amount).
    - Cannot bill the client for these balance amounts.
    - No spenddown amount to report on these claims.
  - ✓ Services not covered by Medicare are used to satisfy the spenddown **NOT** the crossover claim.

How does a provider report the Spenddown amount on a claim?

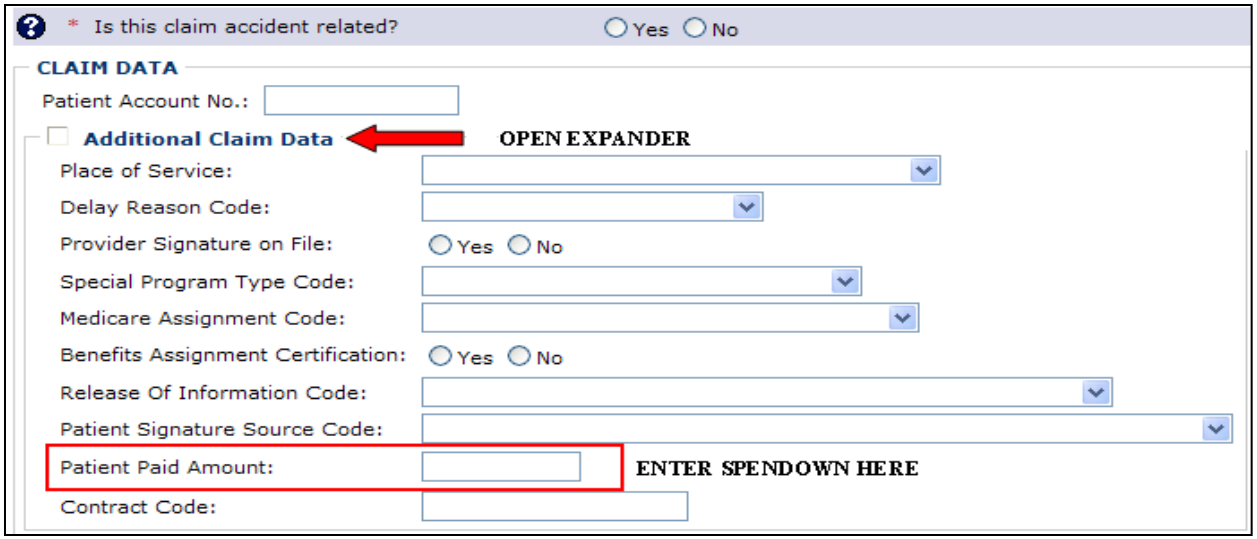
- CMS-1500
  - ✓ Electronic batch claims (837P)
    - HIPAA 5010, Loop 2300 in the
    - Patient Amount Paid segment
      - Use value qualifier F5 in AMT01
      - Then enter the $$ amount in AMT02
  - ✓ Paper claim enter the spenddown
    - In field 19, comments
    - Enter SCI=Y
    - Then enter the $$ amount

How does a provider report the Spenddown amount on a claim?

- UB-04
  - ✓ Entered as a value code
    - Value Code is 66 then enter spenddown amount
    - For an EMER use Value Code D3, then amount
- Dental paper claim enter the spenddown
  - ✓ In field 35, comments
    - Enter SCI=Y
    - Then enter the $$ amount

How does a provider report the Spenddown amount on a claim?

- DDE Professional and Dental claim
  - ✓ At the **"Additional Claim Data"** section expand the section by clicking on the red plus



  - ✓ Enter the spenddown in the Patient Paid Amount field

When can a provider bill the client for their Spenddown amount?

- If your claim is on the award letter as part of the incurred expenses to meet the spenddown.
  - ✓ No award letter? Call 1-800-394-4571

- No waiver form is required to bill the client for their spenddown liability.
  - ✓ Can bill the client only for the spenddown liability amount not the balance of a claim if the Agency makes a payment.

When can a provider bill the Client?

- Provider billed Medicaid for the services and the claim is denied as "Client pending spenddown."
- Client then satisfies spenddown and becomes Medicaid eligible.
- Provider is to check eligibility again before billing the client:
  - ✓ If client is now eligible, bill Medicaid.
  - ✓ If client is eligible and provider has billed client, they need to stop and bill Medicaid.
  - ✓ If the client is eligible and a claim should have been billed to Medicaid, do not send the client to collections but bill Medicaid.

When can a provider bill the Client?

- Client that satisfies spenddown and becomes Medicaid eligible, that eligibility is called retro eligibility.
- Per retro eligibility rules if client has paid anything, refund client and bill Medicaid.
- All billing the client rules apply.
- See the billing the client WAC 182-502-0160 for complete detailed information.

Billing a Client

Billing a Client

- ✓ *Billing a Client, allowing providers, in limited circumstances, to bill fee-for-service or managed care clients for covered healthcare services, and allowing fee-for-service or managed care clients the option to self-pay for covered healthcare services.*
  - ✓ WAC 182-502-0160

Healthcare Service Categories

The groupings of healthcare services listed in the table in WAC 182-501-0060. Healthcare service categories are included or excluded depending on the client's benefits package.

Excluded Services

A set of services that we do not include in the client's benefits package. There is no Exception To Rule (ETR) process available for these services

Covered service

Is a healthcare service contained within a "service category," that is included in a medical assistance benefits package described in WAC 182-501-0060.

Non-covered service

Is a specific healthcare service (for example, cosmetic surgery), contained within a service category that is included in a medical assistance benefits package, for which the Department does not pay without an approved exception to rule (ETR) (see WAC 182-501-0160). **A non-covered service is not an excluded service** (see WAC 182-501-0060).

Non-covered services are identified in WAC 182-501-0070 and in specific health-care program rules

NON-COVERED VS. EXCLUDED

Benefits Package
Healthcare Category of Service

Included services

Covered Service

May Require Limitation Extension, Expedited, or Prior Authorization

NON-COVERED Service

ETR process is available

EXCLUDED services

ETR process is not available

Note: The examples in today's webinar are based on Benefits Packages effective January 1, 2011.

NON-COVERED VS. EXCLUDED

Non-Covered	Excluded for Adults* (no funding for these services)
• Cosmetic surgery • Physician services are covered, however cosmetic surgery is not covered under the physician benefits package.	• Adult Dental • Clients participating in the Developmental Disability Program are exempt.
• Hairpieces or wigs • DME services are covered, however wigs are not covered under the DME benefits package.	• Adult Vision Hardware
• Upright MRI •Diagnostic procedures are covered, but this specific procedure is not covered after a health technology review of its efficacy.	• Adult Hearing Hardware * 21 years of age and older
ETR CAN BE REQUESTED	NO ETR PROCESS AVAILABLE

Note: Examples today are based on Benefits Packages effective January 1, 2011

The client is under the Agency's or an Agency-contracted MCO's patient review and coordination (PRC) program (WAC 182-501-0135) and receives nonemergency services from providers or healthcare facilities other than those to whom the client is assigned or referred under the PRC program.

The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in WAC 388-513-1380, emergency medical expense requirement, deductible, or copayment required by the Agency.)

WHEN CAN A PROVIDER BILL A CLIENT <u>WITHOUT</u> FORM 13-879

The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a medical assistance program.

The client, the client's legal guardian, or the client's legal representative:

- Was reimbursed for the service directly by a third party; or
- Refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third party insurance carrier for the service.

The services were non-covered ambulance services [See WAC 182-546-0250(2)].

The services were provided to a Take Charge – Family Planning Service Only (TCFPO) client, and the services are not within the scope of the client's benefits package.

WHEN CAN A PROVIDER BILL A CLIENT <u>WITHOUT</u> FORM 13-879

An Agency contracted MCO enrollee chooses to receive nonemergency services from providers outside of the MCO's network without authorization from the MCO.

A provider can bill an adult client for **excluded** services.

For example:

Vision hardware

Hearing hardware

Non-emergent adult dental

The service is covered by the Agency with prior authorization, all the requirements for obtaining authorization are completed and was denied, the client completes the administrative hearings process or chooses to forego it or any part of it, and the service remains denied by the Agency as not medically necessary.

The service is covered by the Agency and does not require authorization, but the service is a specific type of treatment, supply, or equipment based on the client's personal preference that the Agency does not pay for. The client completes the administrative hearings process or chooses to forego it or any part of it.

WHEN CAN A PROVIDER BILL A CLIENT <u>WITH</u> FORM 13-879?

If the service is not covered, the provider must inform the client of his or her right to have the provider request an ETR, and the client chooses not to have the provider request an ETR .

The service is not covered by the Agency, the provider requests an ETR and the ETR process is exhausted, and the service is denied.

WHEN CAN A PROVIDER NOT BILL A CLIENT?

Services for which the provider did not correctly bill the Agency or MCO.

If the Agency or MCO returns or denies a claim for correction and resubmission, the client cannot be billed.

Services for which the Agency or MCO denied the authorization because the process was placed on hold pending receipt of requested information but the requested information was not received by the Agency. (WAC 182-501-0165(7)(c)(i))

This includes rejected authorizations, when the authorization request is returned due to missing required information.

The cost difference between an authorized service or item and an "upgraded" service or item preferred by the client (e.g., a wheelchair with more features; brand name versus generic drugs).

WHEN CAN A PROVIDER NOT BILL A CLIENT?

Providers are not allowed to “balance bill” a client.

Missed, cancelled, or late appointments

Shipping and/or postage charges

"Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care.

Services for which the provider has not received payment from the Agency or the client's MCO because the provider did not complete all requirements necessary to obtain payment; (example: billing using a diagnosis code which is not a primary diagnosis code per ICD-9).

Copying, printing, or otherwise transferring healthcare information, as the term healthcare information is defined in chapter 70.02 RCW, to another healthcare provider, which includes, but is not limited to:

Medical/dental charts

Radiological or imaging films

Laboratory or other diagnostic test results

Washington State Health Care Authority Medicaid

Washington State Health Care Authority

Agreement to Pay for Healthcare Services

WAC 182-502-0160 ("Billing a Client")

This is an agreement between a "client" and a "provider," as defined below. The client agrees to pay the provider for healthcare service(s) that the Health Care Authority (HCA) will not pay. Both parties must sign this Agreement. For the purposes of this Agreement, "services" include but are not limited to healthcare treatment, equipment, supplies, and medications.

Client - A recipient of Medicaid or other healthcare benefits through the HCA or a managed care organization (MCO) that contracts with the HCA.
Provider - An institution, agency, business, or person that provides healthcare services to HCA clients and has a signed agreement with the HCA or authorization from an MCO.

This Agreement and WAC 182-502-0160 apply to billing a client for covered and noncovered services as described in WAC 182-501-0050 through WAC 182-501-0070. Providers may not bill any HCA client (including those enrolled with an MCO that contracts with the HCA) for services which the HCA or an MCO that contracts with the HCA may have paid until the provider has completed all requirements for obtaining authorization.

CLIENT'S PRINTED NAME	CLIENT'S ID NUMBER
PROVIDER'S PRINTED NAME	PROVIDER NUMBER

Directions:

- Both the provider and the client must fully complete this form **before** an HCA client receives any service for which this Agreement is required.
- You must complete this form no more than 90 calendar days before the date of the service. If the service is not provided within 90 calendar days, the provider and client must complete and sign a new form.
- The provider and the client must complete this form only **after** they exhaust all applicable HCA or HCA-contracted MCO processes which are necessary to obtain authorization for the requested service(s). These may include the exception to rule (ETR) process for noncovered services as described in WAC 182-501-0160 or the administrative hearing process, if the client chooses to pursue these processes.
- Limited English proficient (LEP) clients must be able to understand this form in their primary language. This may include a translated form or interpretation of the form. If the form is interpreted for the client, the interpreter must also sign and date the form. Both the client and the provider must sign a translated form.

Form 13-879

SPECIFIC SERVICE(S) OR ITEM(S) TO BE PROVIDED AND ANTICIPATED DATE OF SERVICE	CPT/CDT/ HCPC CODE (BILLING CODE)	AMOUNT TO BE PAID BY CLIENT	REASON WHY THE CLIENT IS AGREEING TO BE BILLED (CHECK THE ONE THAT APPLIES FOR EACH SERVICE)	COVERED TREATMENT ALTERNATIVES OFFERED BUT NOT CHOSEN BY CLIENT	DATE(S) ETR REQUESTED/DENIED OR WAIVED, OR PRIOR AUTHORIZATION (PA) REQUESTED/DENIED	
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)
			☐ Noncovered service ☐ Noncovered service, ETR waived ☐ Covered but denied as not medically necessary ☐ Covered, but specific type not paid for		ETR REQUESTED OR WAIVED PA REQUEST	ETR DENIAL (ATTACH HCA NOTICE) PA DENIAL (ATTACH HCA NOTICE)

- I understand that HCA or an MCO that contracts with HCA will not pay for the specific service(s) being requested for one of the following reasons, as indicated in the above table: 1) HCA does not cover the service(s); 2) the service(s) was denied as not medically necessary for me, or 3) the service(s) is covered but the type I requested is not.
- I understand that I can, but may choose not to: 1) ask for an Exception to Rule (ETR) after an HCA or HCA-contracted MCO denial of a request for a noncovered service; or 2) ask for a hearing to appeal an HCA or HCA-contracted MCO denial of a requested service.
- I have been fully informed by this provider of all available medically appropriate treatment, including services that may be paid for by the HCA or an HCA-contracted MCO, and I still choose to get the specified service(s) above.
- I understand that HCA does not cover services ordered by, prescribed by, or are a result of a referral from a healthcare provider who is not contracted with HCA as described in Chapter 182-502 WAC.
- ***I agree to pay the provider directly for the specific service(s) listed above.***
- I understand the purpose of this form is to allow me to pay for and receive service(s) for which HCA or an HCA-contracted MCO will not pay. This provider answered all my questions to my satisfaction and has given me a completed copy of this form.
- I understand that I can call HCA at 1-800-562-3022 to receive additional information about my rights or services covered by HCA under fee-for-service or managed care.

I AFFIRM: I understand and agree with this form's content, including the bullet points above.	CLIENT'S OR CLIENT'S LEGAL REPRESENTATIVE'S SIGNATURE	DATE
I AFFIRM: I have complied with all responsibilities and requirements as specified in WAC 182-502-0160.	PROVIDER OF SERVICE(S) SIGNATURE	DATE
I AFFIRM: I have accurately interpreted this form to the best of my ability for the client signing above.	INTERPRETER'S PRINTED NAME AND SIGNATURE	DATE

Ambulance Services / ITA

Ambulance Services

- Ambulance Transports (Usually Emergency Only)
- Two types of transports covered:
  - ✓ Air Transports
  - ✓ Ground Transports
- Covered codes are listed in the Ambulance Billing Instructions (BI).
- Only a few procedure codes allowed for billing:
  - ✓ Basic Transport
  - ✓ Mileage
  - ✓ Other (Tolls, Extra Attendant)
- Billing requires the Origin/Destination Modifiers
- Transports need to be Medically Necessary. (Check BI's for requirements)

Involuntary Treatment Act (ITA) Services

Note: The Involuntary Treatment Act applies to all individuals within the borders of the state of Washington. An involuntarily–detained consumer does not have to be Medicaid eligible. The Department will pay the ITA transportation costs for any consumer that a DMHP determines is in need of ITA services.

- Under no circumstances will the Department pay for transportation costs to or from out-of-state or bordering cities for clients under ITA.

- Please visit the Department's Division of Behavioral Health and Recovery (DBHR) website for a list of RSNs that you may contact regarding ITA services: http://www1.dshs.wa.gov/mentalhealth/rsnmap.shtml

- The Department receives and processes claims, but all claims are funded through DBHR

Involuntary Treatment Act (ITA) Services

- The Involuntary Treatment Act (ITA), Chapter 71.05 RCW (adults) and Chapter 71.34 RCW (minors), provides for the involuntary detention of individuals who are assessed by a Regional Support Network Designated Mental Health Professional (DMHP) as being:
  - ✓ A danger to themselves;
  - ✓ A danger to others; or
  - ✓ Gravely disabled.

- The DMHP will determine the appropriate transportation method:
  - ✓ Local law enforcement
  - ✓ Ambulance

Involuntary Treatment Act (ITA) Services

- Clients that are currently eligible:
  - ✓ All claims billed must have the Special Claim Indicator of "**SCI=I**" on claim:
    - CMS 1500 in box 19
    - DDE and Electronic submissions in the claim note section

- Clients that are **NOT** currently eligible:
  - ✓ All claims billed must have the Special Claim Indicator of "**SCI=I**" on claim:
    - CMS 1500 in box 19
    - DDE and Electronic submissions in the claim note section
    - Requires ITA backup documentation

Involuntary Treatment Act (ITA) Services – Not Eligible Clients

- Must include backup detention documentation dated within 20 days of transport and consist of a DMHP-generated form following Superior Court Mental Proceedings Rule 2.2. Documentation must include:

  - ✓ The name of the person taken into custody.
  - ✓ A statement that the person authorized to take custody is authorized pursuant to RCW 71.05.150(1) (d) or RCW 71.05.150(2).

Involuntary Treatment Act (ITA) Services – Not Eligible Clients (Cont.)

- ✓ A statement that the person is to be taken into custody for the purpose of delivering that person to an evaluation and treatment facility for a period of up to 72 hours excluding Saturdays, Sundays, and holidays. The 72-hour period begins when the evaluation and treatment facility provisionally accepts the person as provided in RCW 71.05.170.

- ✓ A statement specifying the name and location of the evaluation and treatment facility where such person will be detained.

Family Planning

Family Planning

- Tips for billing Family Planning Services.
  - ✓ http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/FamilyPlanning_Prov.html
  - ✓ Approved provider
  - ✓ Correct Taxonomy code
    - Take Charge Provider 261QA0005X
  - ✓ Correct Diagnosis code
    - V25 series excluding V25.3

Newborn

Billing a Newborn

When billing for a newborn claim:

1.)Place mom's ID in the Client ID field

2.) Place baby's information in the additional subscriber/client information fields:

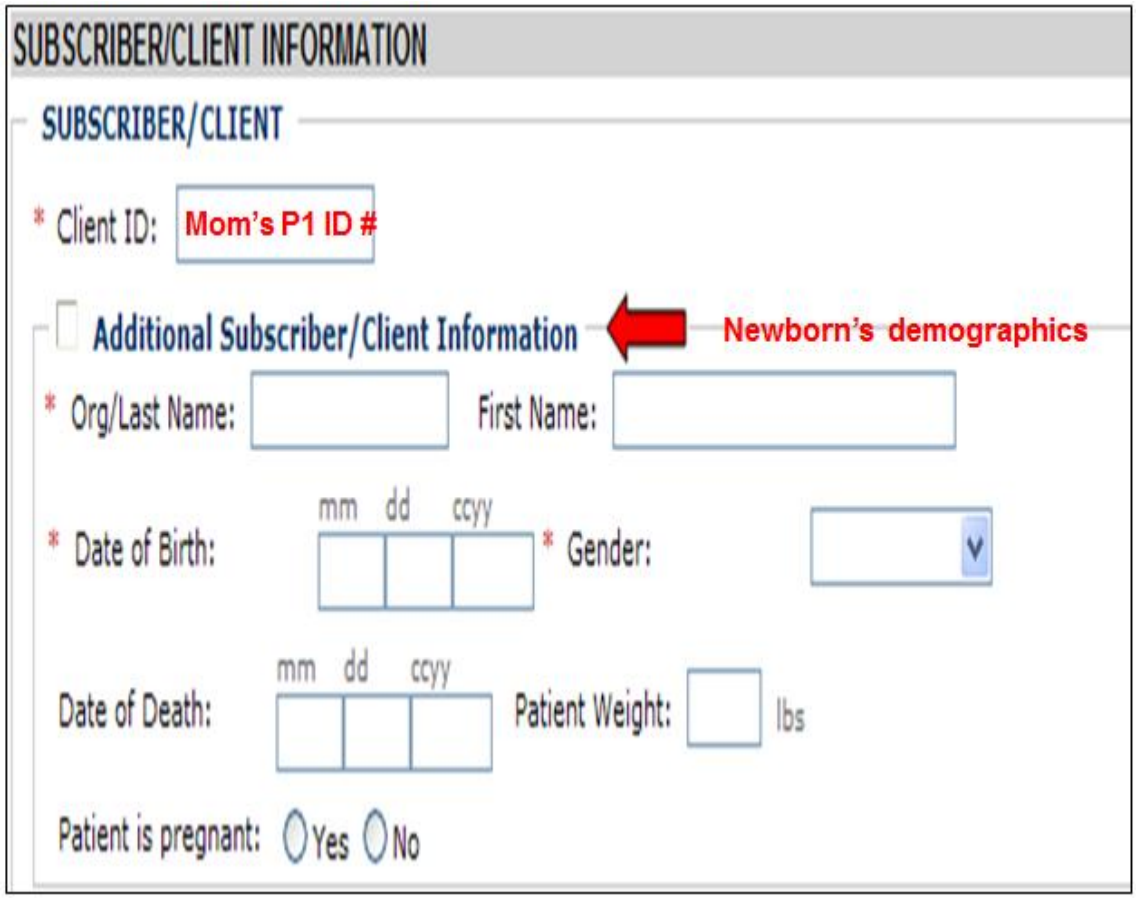
a.)enter the baby's name, baby's birthdates, and the baby's gender in the boxes instead of mom's information.

3.) DDE and paper claims require a claim note

a.) SCI=B

Note:

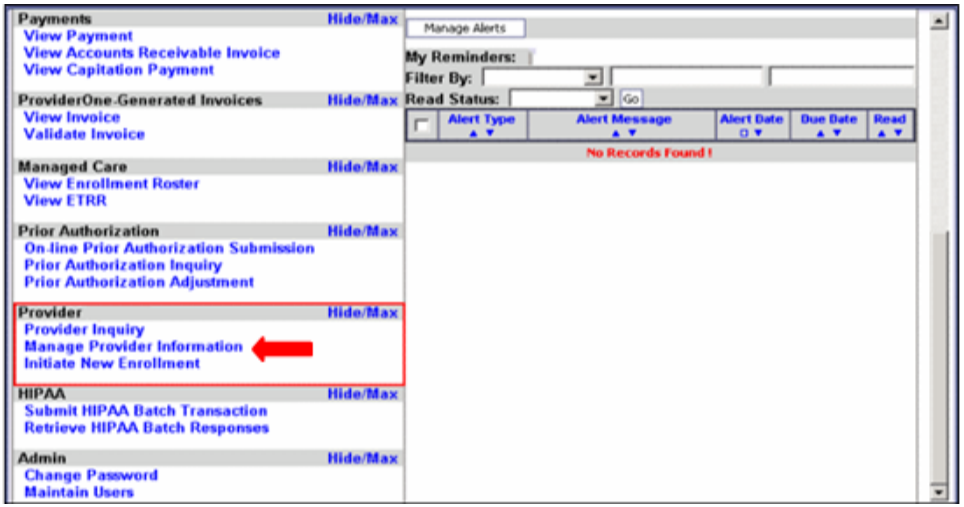
Newborns of clients enrolled with a PCCM provider are fee-for-service until the client chooses a PCCM for the newborn. Bill all services for the newborn to the Agency.



Provider File Maintenance

Provider File Maintenance

- Modifying Provider File Information
  - ✓ Log into ProviderOne with the **Provider File Maintenance** or **Supers User** profile.
  - ✓ Click on the **Manage Provider Information** hyperlink



Provider Types include:

- ✓ Individual
- ✓ Group
- ✓ Tribal
- ✓ Facilities (FAOI)
- ✓ Servicing

- ✓ Go to web page http://hrsa.dshs.wa.gov/provider/provideronemanuals.shtml for the different of provider file update modification manuals.

Provider File Maintenance

- Modifying Provider File Information
  - ✓ The Business Process Wizard contains the steps for modification. Click on the step hyperlink to modify.

View/Update Provider Data - Group Practice:

Business Process Wizard - Provider Data Modification (Group Practice). In order to finalize submission of your requested changes, you must c

Step	Required	Last Modification Date	Last Review Date	Status
Step 1: Basic Information	Required	09/30/2009	09/30/2009	Complete
Step 2: Locations	Required	09/30/2009	09/30/2009	Complete
Step 3: Specializations	Required	06/15/2010	07/22/2010	Complete
Step 4: Ownership Details	Required	09/30/2009	09/30/2009	Complete
Step 5: Licenses and Certifications	Required	06/15/2010	07/22/2010	Complete
Step 6: Training and Education	Optional	09/30/2009	09/30/2009	Complete
Step 7: Identifiers	Optional	09/30/2009	09/30/2009	Complete
Step 8: Contract Details	Optional	09/30/2009	09/30/2009	Complete
Step 9: Federal Tax Details	Required	09/30/2009	09/30/2009	Complete
Step 10: Invoice Details	Optional	09/30/2009	09/30/2009	Complete
Step 11: EDI Submission Method	Optional	09/30/2009	09/30/2009	Complete
Step 12: EDI Billing Software Details	Optional	09/30/2009	09/30/2009	Complete
Step 13: EDI Submitter Details	Required	01/19/2011	01/19/2011	Complete
Step 14: EDI Contact Information	Optional	05/10/2010	05/10/2010	Complete
Step 15: Servicing Provider Information	Required	08/31/2011	09/06/2011	Complete
Step 16: Payment Details	Required	09/30/2009	09/30/2009	Complete
Step 17: Submit Modification for Review	Required	09/30/2009	09/30/2009	Complete

Provider File Maintenance

- Step 3:Specializations (Taxonomy Codes)

Close | Add | Update

Note: Provider Type and Specialty/Subspecialty are your Taxonomy Codes.

Specialty/Subspecialty List:

Filter By : And

Status: Active Go

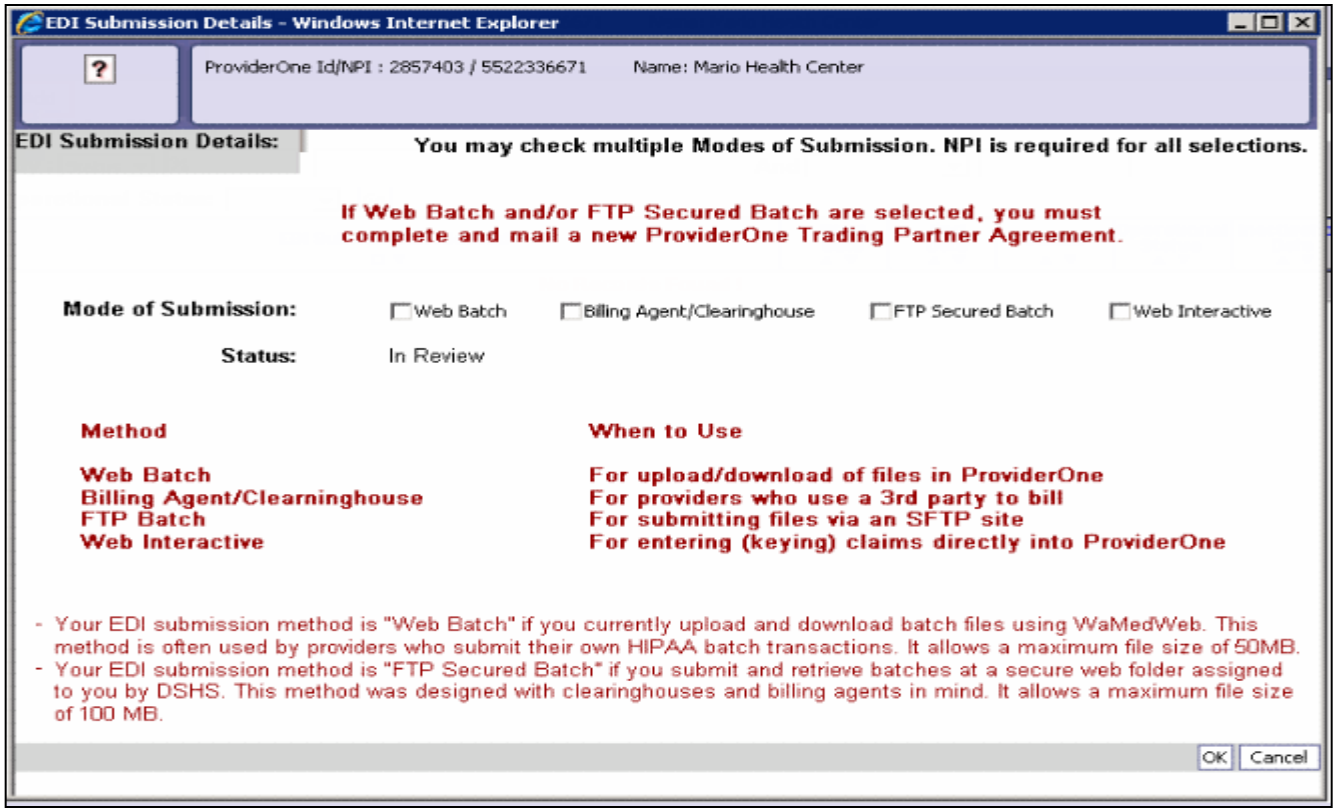
	Provider Type	Specialty/Subspecialty	Administration	Start Date	End Date	Operational Status	Status
☐	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/V0102-Vascular Neurology	HRSA	05/01/1998	12/31/2999	Active	Approved
☐	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/V0102-Vascular Neurology	MHD	05/01/1998	12/31/2999	Active	Approved
☐	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/S0012-Sleep Medicine	HRSA	05/01/1998	12/31/2999	Active	Approved
☐	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/S0012-Sleep Medicine	MHD	05/01/1998	12/31/2999	Active	Approved
☐	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/S0010-Sports Medicine	MHD	05/01/1998	12/31/2999	Active	Approved
☐	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/S0010-Sports Medicine	HRSA	05/01/1998	12/31/2999	Active	Approved
☐	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/P2900-Pain Medicine	MHD	05/01/1998	12/31/2999	Active	Approved
☐	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/P2900-Pain Medicine	HRSA	05/01/1998	12/31/2999	Active	Approved
☐	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/P0805-Geriatric Psychiatry	HRSA	05/01/1998	12/31/2999	Active	Approved
☐	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/P0805-Geriatric Psychiatry	MHD	05/01/1998	12/31/2999	Active	Approved

<< Prev | Viewing Page 1 | Next >> | 2 | Go | Page Count | SaveToXLS

- ✓ The first specialization taxonomy code is 20-84-V0102 then add a "**X**" to all or (2084V0102X).

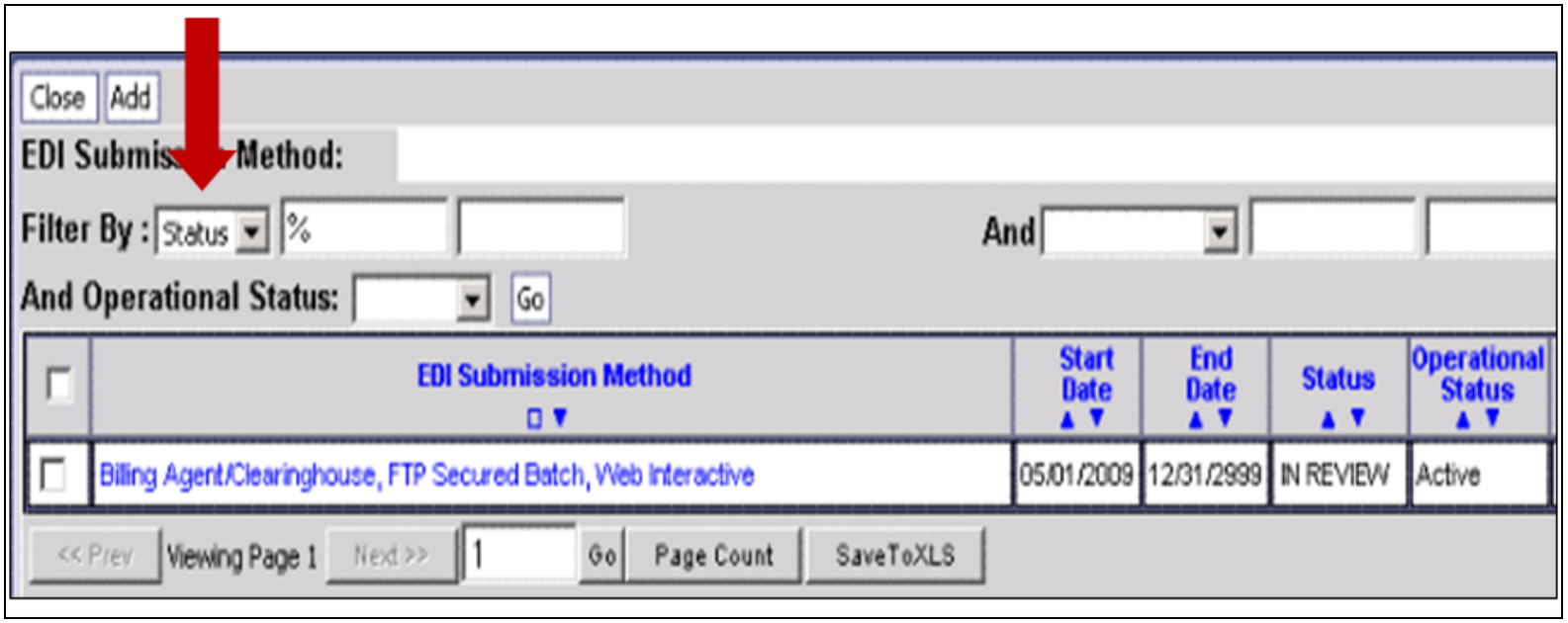
Provider File Maintenance

- Step 11:EDI Submission Method
  - ✓ How are you going to bill us?



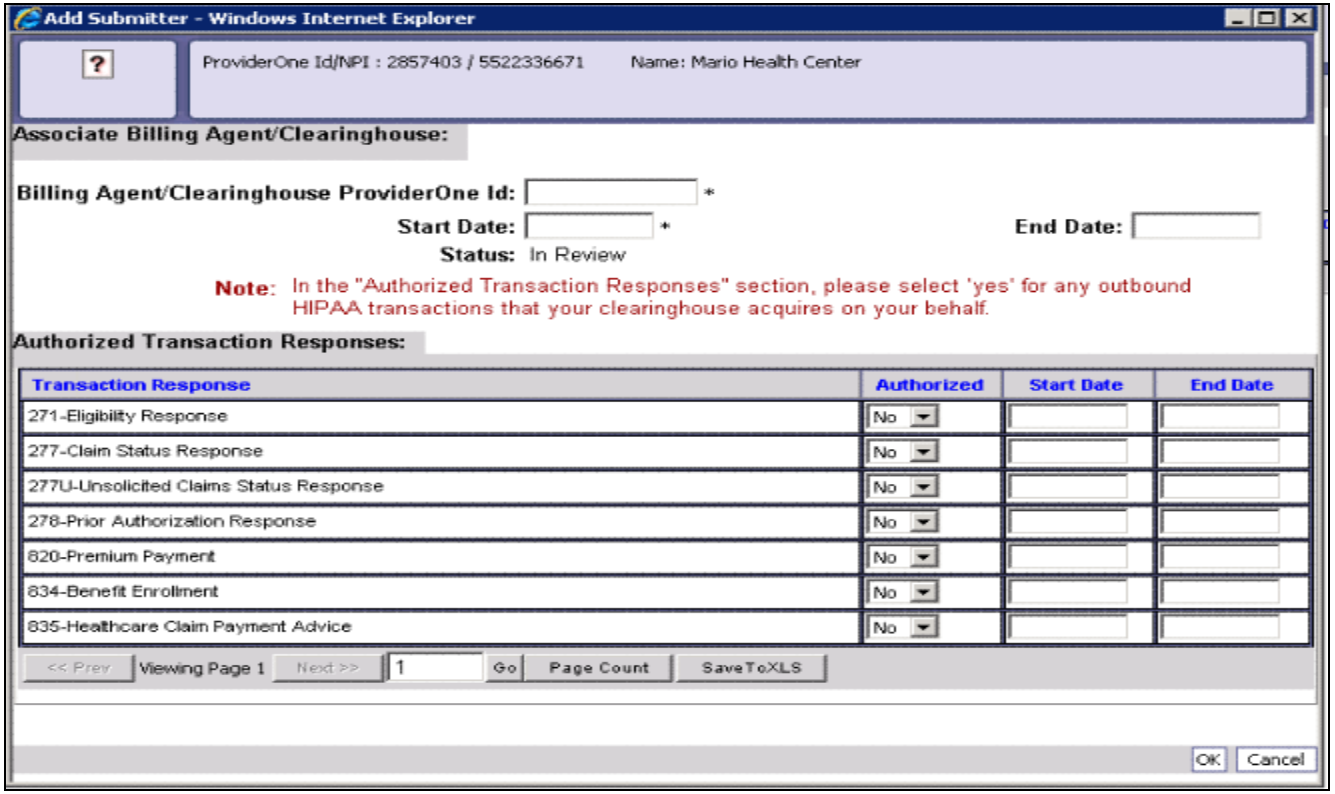
Provider File Maintenance

- Step 11:EDI Submission Method
  - ✓ Filter By: Status then add % and click Go



Provider File Maintenance

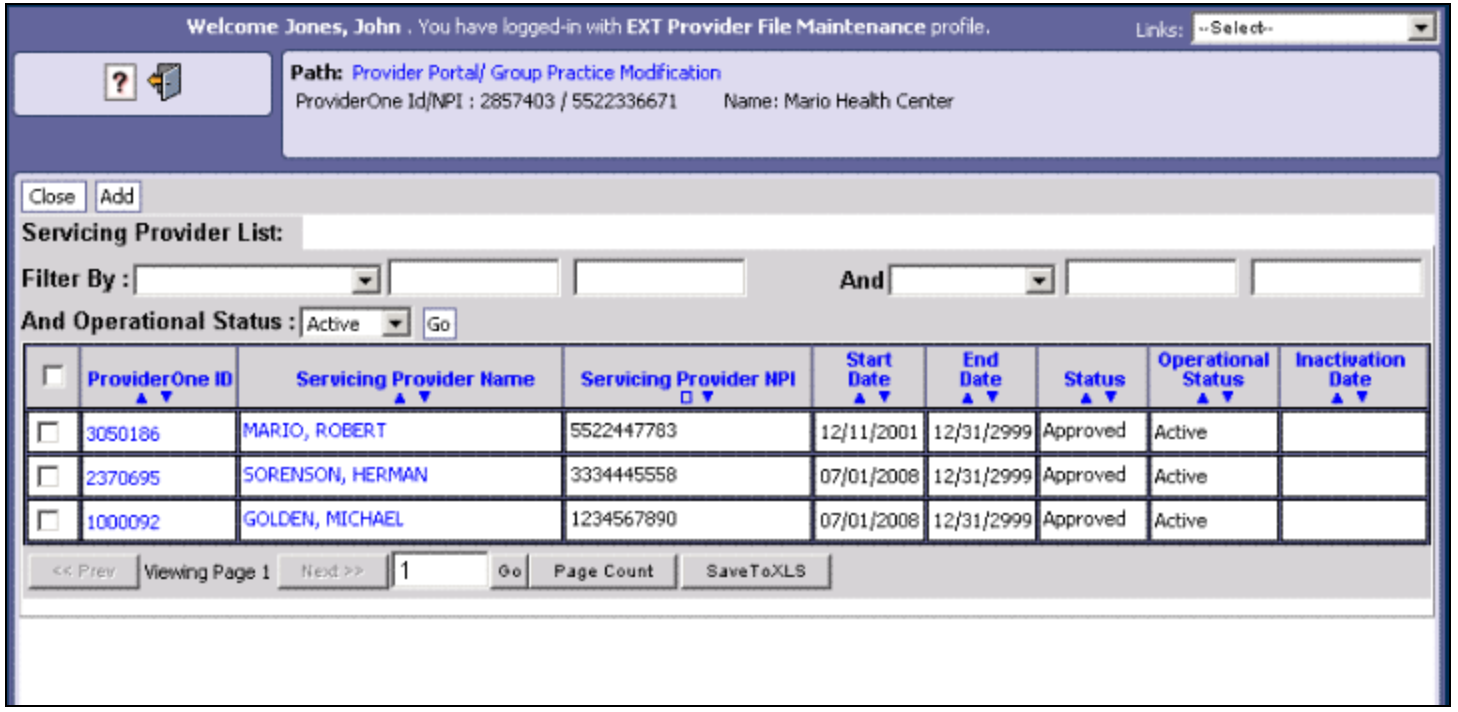
- Step 13:EDI Submitter Details.



http://hrsa.dshs.wa.gov/providerone/HIPAAtesting.htm

Provider File Maintenance

- Step 15: Servicing Provider Information



Welcome Jones, John . You have logged-in with EXT Provider File Maintenance profile. Links: --Select--

Path: Provider Portal/ Group Practice Modification
ProviderOne Id/NPI : 2857403 / 5522336671 Name: Mario Health Center

Close Add

Servicing Provider List:

Filter By : And

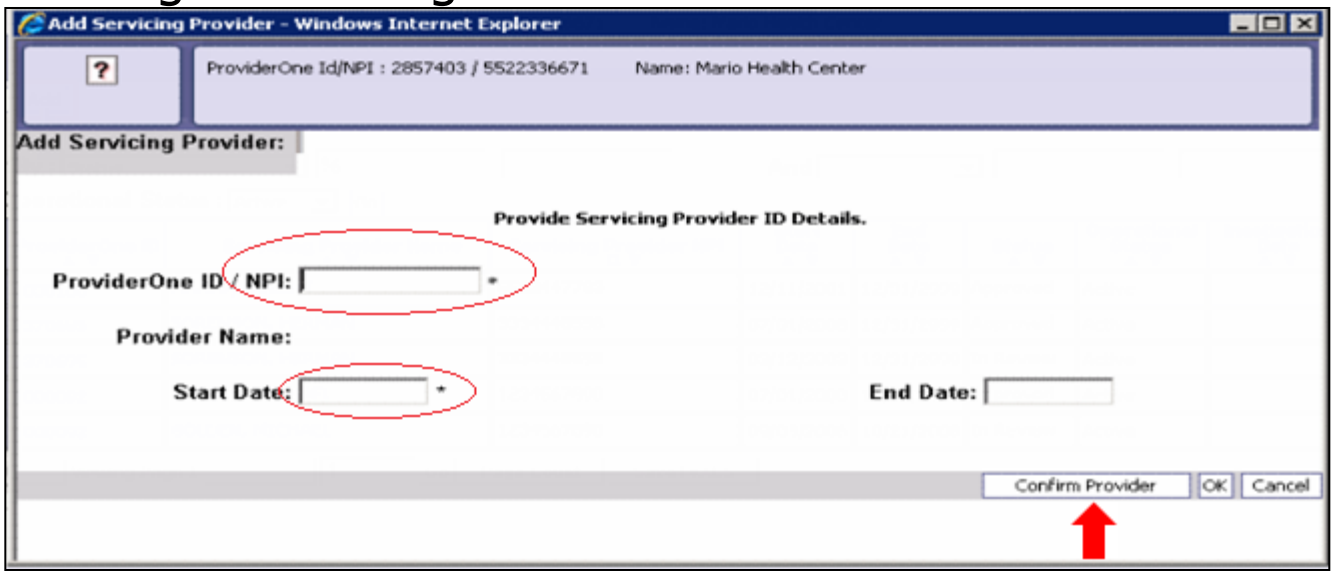
And Operational Status : Active Go

	ProviderOne ID	Servicing Provider Name	Servicing Provider NPI	Start Date	End Date	Status	Operational Status	Inactivation Date
☐	3050186	MARIO, ROBERT	5522447783	12/11/2001	12/31/2999	Approved	Active	
☐	2370695	SORENSON, HERMAN	3334445558	07/01/2008	12/31/2999	Approved	Active	
☐	1000092	GOLDEN, MICHAEL	1234567890	07/01/2008	12/31/2999	Approved	Active	

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

Provider File Maintenance

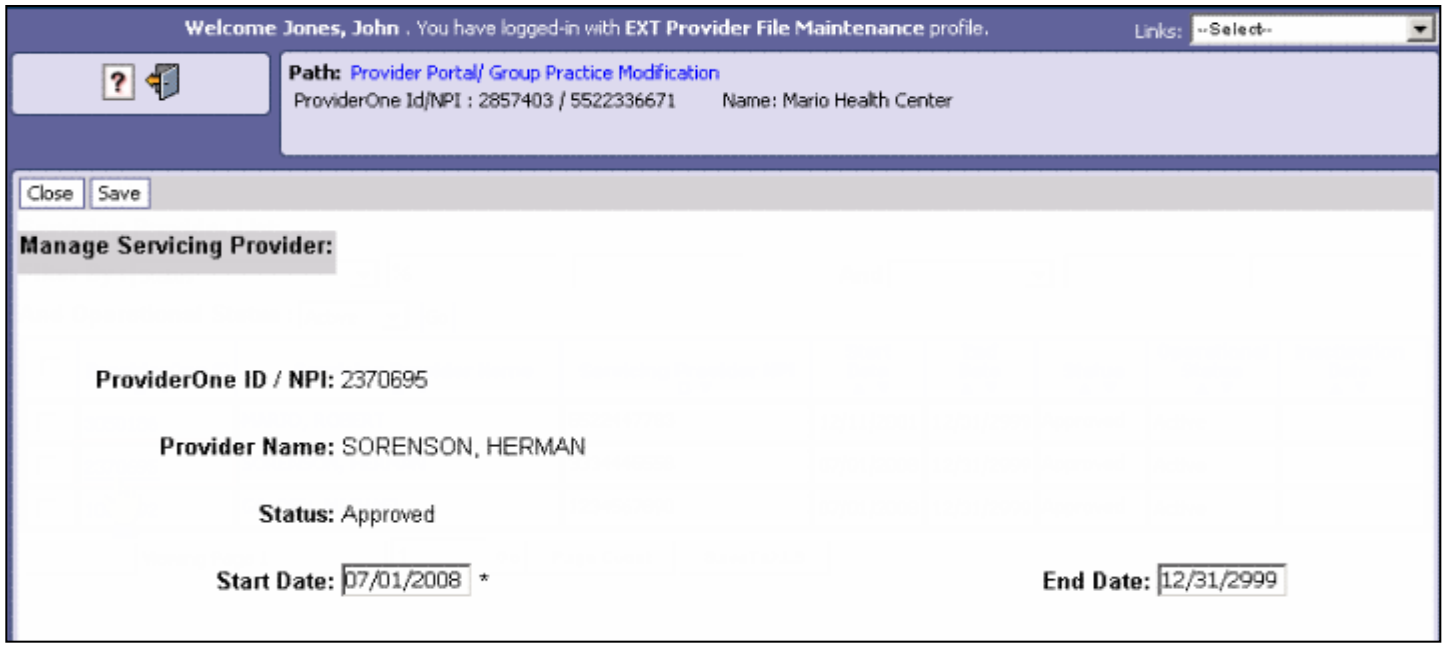
- Step 15: Servicing Provider Information
  - ✓ Adding a Servicing Provider



  - ✓ Enter the providers NPI number and start date at your clinic
  - ✓ Click on the Confirm Provider button

Provider File Maintenance

- Step 15:Servicing Provider Information
  - ✓ Ending a provider association



  - ✓ Enter an end date then save the change

Provider File Maintenance

- Step 15:Servicing Provider Information
  - ✓ Viewing a Servicing Providers taxonomy codes

Close | Required Credentials | Undo Update

Important - Step 11: EDI Submission Method is REQUIRED if FTP/Web Batch Submitter or Retrieving 835s.

View/Update Provider Data - Individual:

Servicing Provider Business Process Wizard

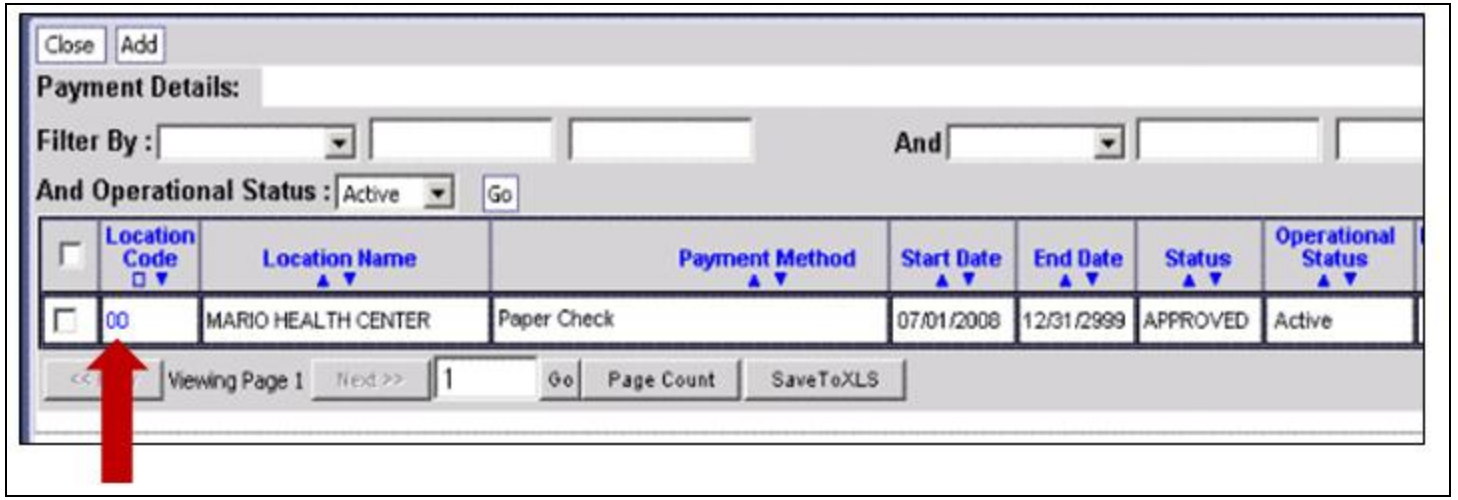
Business Process Wizard - Provider Data Modification (Individual). In order to finalize submission of your requested changes, you must comple

	Step	Required	Last Modification Date	Last Review Date	Status
☐	Step 1: Basic Information	Required	11/06/2010	11/06/2010	Complete
☐	Step 2: Locations	Not Required	11/06/2010	11/06/2010	Complete
☐	Step 3: Specializations	Required	11/06/2010	11/06/2010	Complete
☐	Step 4: Ownership Details	Not Required	11/06/2010	11/06/2010	Complete
☐	Step 5: Licenses and Certifications	Required	11/06/2010	11/06/2010	Complete
☐	Step 6: Training and Education	Optional	11/06/2010	11/06/2010	Complete
☐	Step 7: Identifiers	Optional	11/06/2010	11/06/2010	Complete
☐	Step 8: Contract Details	Not Required	11/06/2010	11/06/2010	Complete
☐	Step 9: Federal Tax Details	Optional	11/06/2010	11/06/2010	Complete
☐	Step 10: Invoice Details	Not Required	11/06/2010	11/06/2010	Complete
☐	Step 11: EDI Submission Method	Not Required	11/06/2010	11/06/2010	Complete
☐	Step 12: EDI Billing Software Details	Not Required	11/06/2010	11/06/2010	Complete
☐	Step 13: EDI Submitter Details	Not Required	11/06/2010	11/06/2010	Complete
☐	Step 14: EDI Contact Information	Not Required	11/06/2010	11/06/2010	Complete
☐	Step 15: Billing Provider Details	Optional	11/06/2010	11/06/2010	Complete
☐	Step 16: Payment Details	Not Required	11/06/2010	11/06/2010	Complete
☐	Step 17: View Union Information	Required	11/06/2010	11/06/2010	Complete
☐	Step 18: Submit Modification for Review	Required	11/06/2010	11/06/2010	Complete

  - ✓ Click on Step 3: Specializations to see the taxonomy

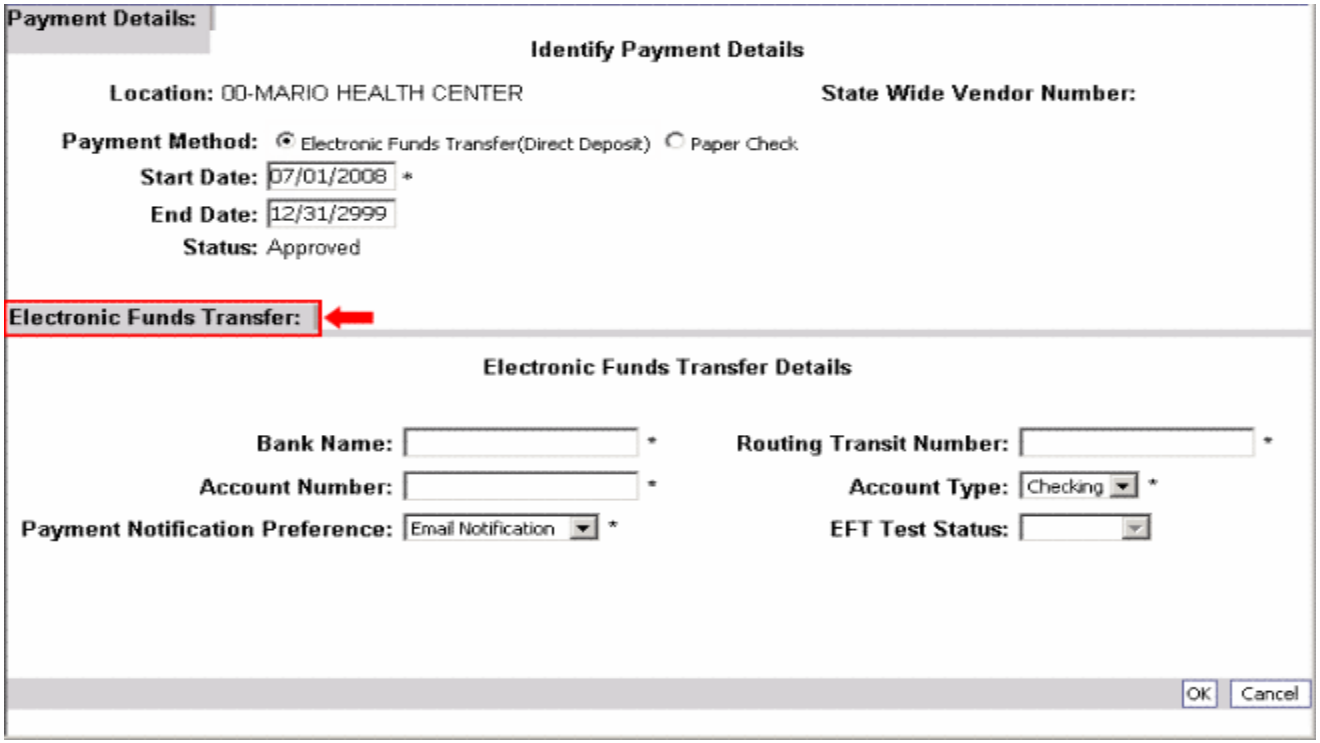
Provider File Maintenance

- Step 16:Payment Details
  - ✓ Displayed is current payment information.
  - ✓ To modify click on the "**00**".



Provider File Maintenance

- Step 16: Payment Details
  - ✓ Switching to Electronic Funds Transfer (preferred)



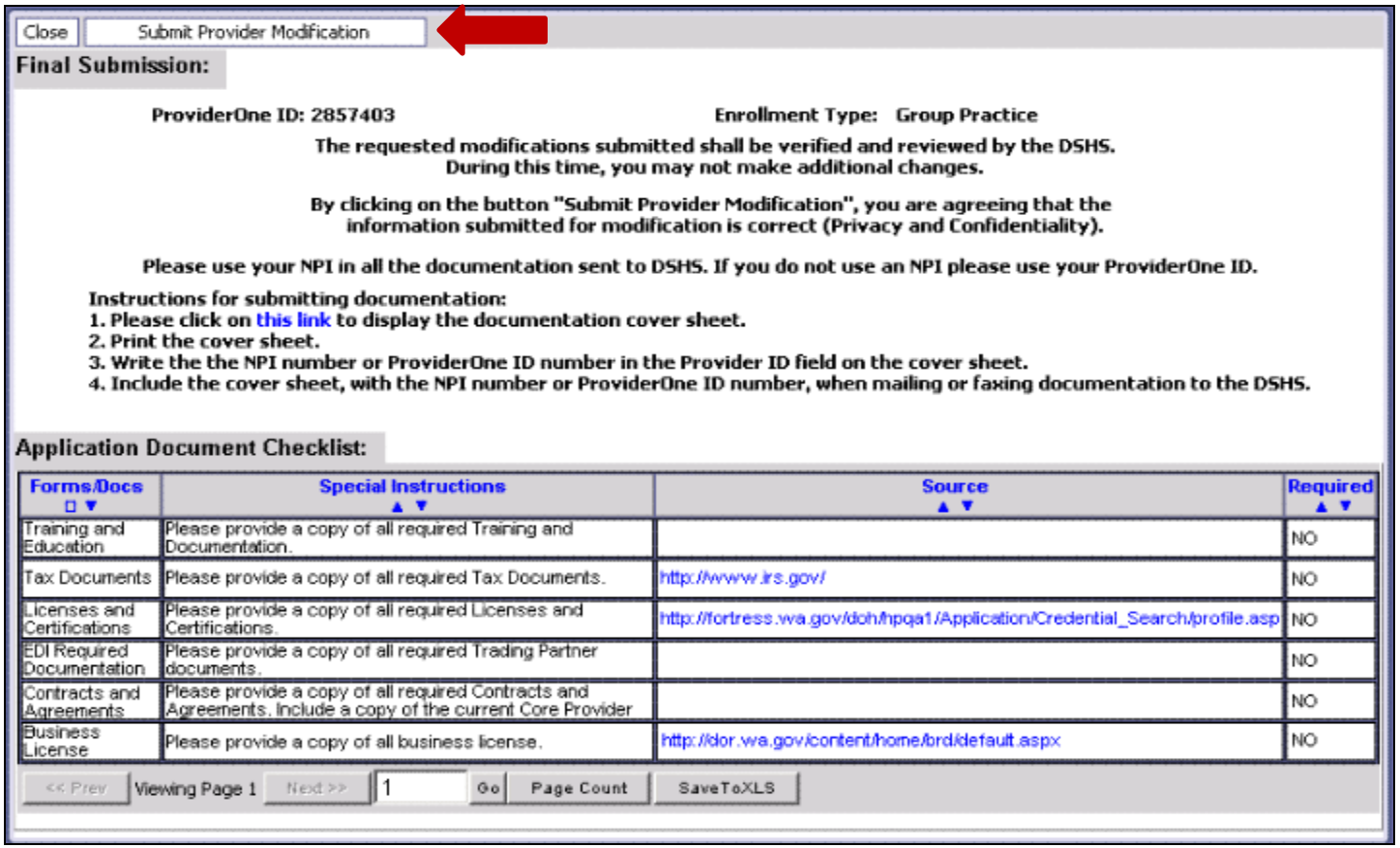
  - ✓ Enter your banking information then click **"OK"**

Provider File Maintenance

- Step 16:Payment Details
  - ✓ Fill out the Authorization Agreement for Electronic Funds Transfer form
  - ✓ Have the form signed
  - ✓ Fax in to 360-725-2144; or
  - ✓ Mail to address on the form
  - ✓ http://www.dshs.wa.gov/pdf/ms/forms/18_633.pdf

Provider File Maintenance

- Step 17:Submit Modification for Review



Close | Submit Provider Modification

Final Submission:

ProviderOne ID: 2857403 **Enrollment Type: Group Practice**

The requested modifications submitted shall be verified and reviewed by the DSHS. During this time, you may not make additional changes.

By clicking on the button "Submit Provider Modification", you are agreeing that the information submitted for modification is correct (Privacy and Confidentiality).

Please use your NPI in all the documentation sent to DSHS. If you do not use an NPI please use your ProviderOne ID.

Instructions for submitting documentation:
1. **Please click on this link to display the documentation cover sheet.**
2. **Print the cover sheet.**
3. **Write the the NPI number or ProviderOne ID number in the Provider ID field on the cover sheet.**
4. **Include the cover sheet, with the NPI number or ProviderOne ID number, when mailing or faxing documentation to the DSHS.**

Application Document Checklist:

Forms/Docs	Special Instructions	Source	Required
Training and Education	Please provide a copy of all required Training and Documentation.		NO
Tax Documents	Please provide a copy of all required Tax Documents.	http://www.irs.gov/	NO
Licenses and Certifications	Please provide a copy of all required Licenses and Certifications.	http://fortress.wa.gov/doh/hpqa1/Application/Credential_Search/profile.asp	NO
EDI Required Documentation	Please provide a copy of all required Trading Partner documents.		NO
Contracts and Agreements	Please provide a copy of all required Contracts and Agreements. Include a copy of the current Core Provider		NO
Business License	Please provide a copy of all business license.	http://dor.wa.gov/content/home/brd/default.aspx	NO

<< Prev | Viewing Page 1 | Next >> | 1 | Go | Page Count | SaveToXLS

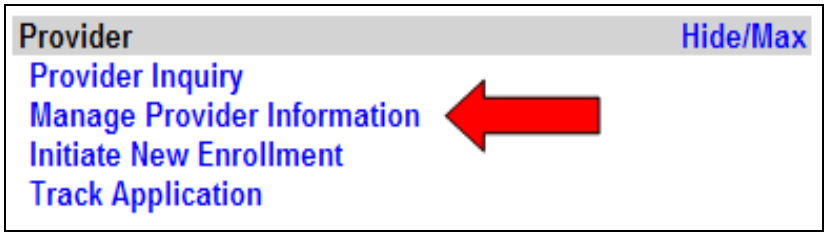
Provider File Maintenance

- More information on provider file maintenance visit this site:
- http://hrsa.dshs.wa.gov/provider/provideronemanuals.shtml
- Find your manual to review.

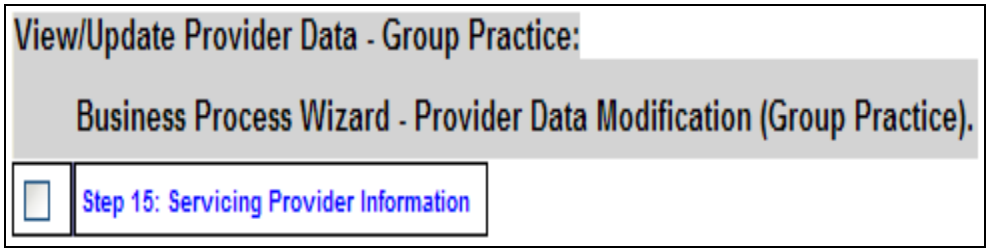
Enroll a New Rendering Provider

Enroll a New Rendering Provider- Existing Provider

- Log into ProviderOne using the File Maintenance or Super User profile.



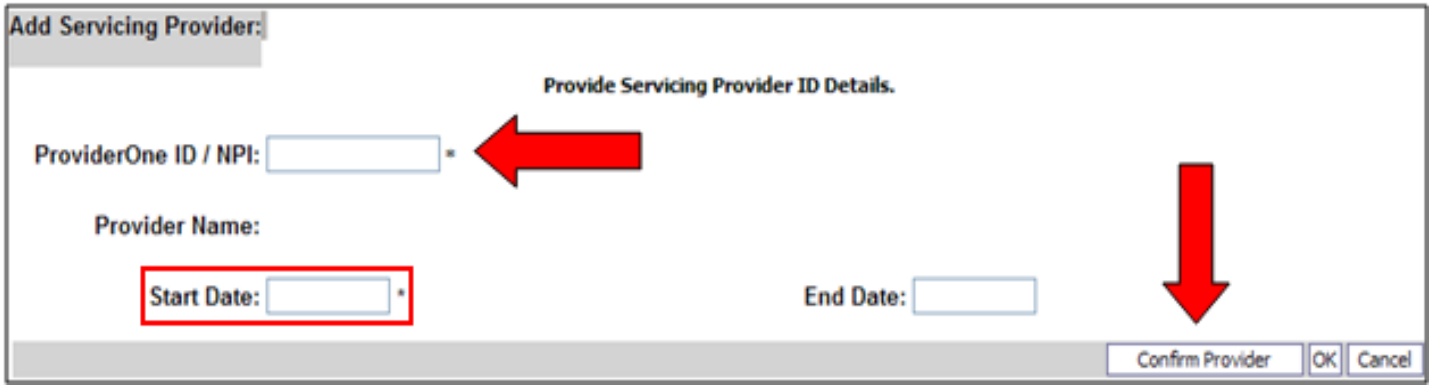
Under Provider click on the hyperlink **"Manage Provider Information"**.



At the Business Process Wizard click on **"Step 15: Servicing Provider Information"**.

Enroll a New Rendering Provider- Existing Provider

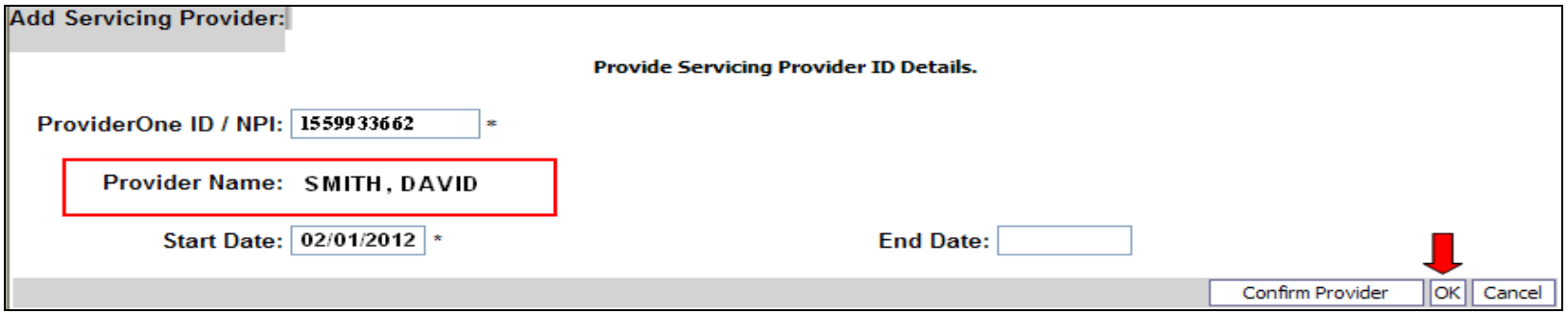
- When the Servicing Provider List opens, click on the **"Add"** button.



- At the Add screen:
  - ✓ Enter the providers NPI.
  - ✓ Enter their start date at your clinic.
  - ✓ Click on the **"Confirm Provider"** button.

Enroll a New Rendering Provider- Existing Provider

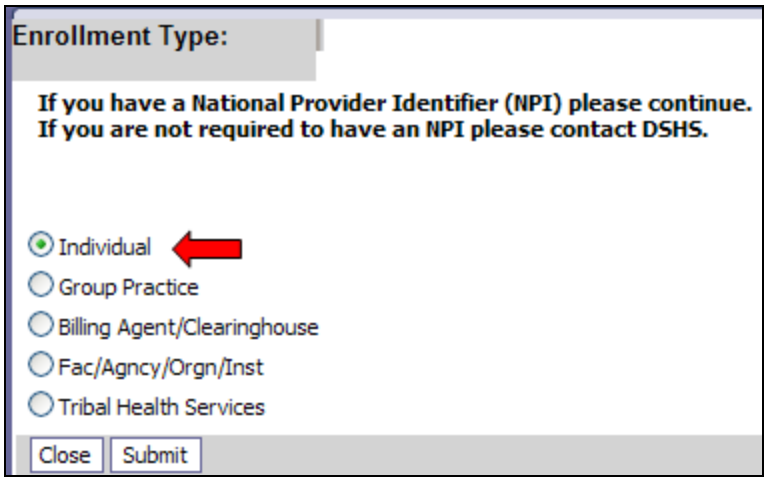
- If the provider is already entered into ProviderOne their name will be confirmed.



- Click the **"OK"** button to add the provider to your list.
- Remember to click **"Step 18: Submit Modification for Review"**.
- The State will then review your request.

Adding a New Rendering Provider

- There are two ways to add a new provider to your domain:
  - ✓ Follow the steps above. When you **"Confirm"** the provider and they are not in the system follow the steps below to enroll them.
  - ✓ At your Portal click on **"Initiate New Enrollment"** hyperlink.



- ✓ Click on **"Individual"** to add the rendering/servicing provider to your domain.
- ✓ Click on the **"Submit"** button.

Adding a New Rendering Provider

- At the Basic Information page for the rendering provider enrollment:

Basic Information: If you don't have NPI and if you are Atypical provider then please contact DSHS worker to enroll.

Tax Identifier Type: ○ FEIN ◉ SSN

Organization Name: (as shown on Income Tax Return)
Organization Business Name: FEIN:

First Name: JOHN (as shown on Social Security Card) Middle Name or Middle Initial: L
Last Name: SMITH (as shown on Social Security Card)
Suffix: MD Gender: Male
SSN: 002272012 Title:
Date of Birth: 07/15/1985 Servicing Type: Servicing Only

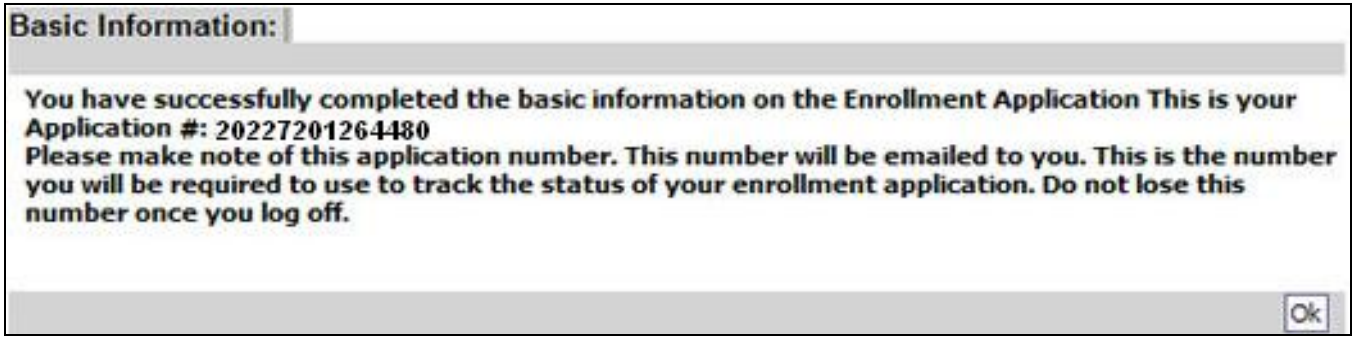
NPI: 1567890234 * UBI:
W-9 Entity Type: Other * W-9 Entity Type (If Other): SERVICING ONLY
Other Organizational Information: ---SELECT--- Email Address:
Enrollment Effective Date: 02/01/2012
Receive Invoice for Medical Services?: No *

Finish Cancel

- ✓ **Most important check the SSN radio button!**
- ✓ When filling in the rest of the data fields be sure to select **"Servicing Only"** as the Servicing Type.

Adding a New Rendering Provider

- Once the Basic Information page is filled in click the **"Finish"** button.
- The basic information on the enrollment application is submitted into ProviderOne which generates the Application number.



- Be sure to record this application number for use in tracking the status of the enrollment application. Then click **"OK"**

Adding a New Rendering Provider

- The Business Process Wizard - Step 1 is complete.

Close | Required Credentials | Undo Update

Important - Step 11: EDI Submission Method is REQUIRED if FTP/Web Batch Submitter or Retrieving 835s.

View/Update Provider Data - Individual:

Business Process Wizard - Provider Data Modification (Individual). In order to finalize submission of your requested - Su

Step	Required	Last Modification Date	Last Review Date	Status
Step 1: Basic Information	Required	03/01/2012	03/01/2012	Complete
Step 2: Locations	Not Required			Incomplete
Step 3: Specializations	Required			Incomplete
Step 4: Ownership Details	Not Required			Incomplete
Step 5: Licenses and Certifications	Required			Incomplete
Step 6: Training and Education	Optional			Incomplete
Step 7: Identifiers	Optional			Incomplete
Step 8: Contract Details	Not Required			Incomplete
Step 9: Federal Tax Details	Optional			Incomplete
Step 10: Invoice Details	Optional			Incomplete
Step 11: EDI Submission Method	Optional			Incomplete
Step 12: EDI Billing Software Details	Optional			Incomplete
Step 13: EDI Submitter Details	Optional			Incomplete
Step 14: EDI Contact Information	Optional			Incomplete
Step 15: Billing Provider Details	Optional			Incomplete
Step 16: Payment Details	Not Required			Incomplete
Step 17: View Union Information	Optional			Incomplete
Step 18: Submit Modification for Review	Required			Incomplete

- ✓ Not all remaining steps are required.

Adding a New Rendering Provider

- The steps with the arrows should be filled out.

Close | Required Credentials | Undo Update

Important - Step 11: EDI Submission Method is REQUIRED if FTP/Web Batch Submitter or Retrieving 835s.

View/Update Provider Data - Individual:

Business Process Wizard - Provider Data Modification (Individual). In order to finalize submission of your requested - Su

	Step	Required	Last Modification Date	Last Review Date	Status
☐	Step 1: Basic Information	Required	03/01/2012	03/01/2012	Complete
☐	Step 2: Locations	Not Required			Incomplete
☐	Step 3: Specializations ⟷	Required			Incomplete
☐	Step 4: Ownership Details	Not Required			Incomplete
☐	Step 5: Licenses and Certifications ⟷	Required			Incomplete
☐	Step 6: Training and Education	Optional			Incomplete
☐	Step 7: Identifiers ⟷	Optional			Incomplete
☐	Step 8: Contract Details	Not Required			Incomplete
☐	Step 9: Federal Tax Details	Optional			Incomplete
☐	Step 10: Invoice Details	Optional			Incomplete
☐	Step 11: EDI Submission Method	Optional			Incomplete
☐	Step 12: EDI Billing Software Details	Optional			Incomplete
☐	Step 13: EDI Submitter Details	Optional			Incomplete
☐	Step 14: EDI Contact Information	Optional			Incomplete
☐	Step 15: Billing Provider Details ⟷	Optional			Incomplete
☐	Step 16: Payment Details	Not Required			Incomplete
☐	Step 17: View Union Information	Optional			Incomplete
☐	Step 18: Submit Modification for Review ⟷	Required			Incomplete

Adding a New Rendering Provider

- Step 3: Specializations
  - ✓ Add Taxonomy here.
- Step 5: Licenses and Certifications
  - ✓ Enter license/certification issued by the Department of Health.
- Step 7: Identifiers
  - ✓ If you have a Drug Enforcement Agency (DEA) number enter it here

Adding a New Rendering Provider (Cont.)

- Step 15: Billing Provider Details
  - ✓ Add the NPI and Name of clinic that will bill for this rendering provider's services.
- Step 18: Submit Modification for Review
  - ✓ Open this and click the Submit Button to send to the State for approval.
- Send in all required supporting documentation (CPA, Certifications, etc)

HIPAA Transactions

HIPAA Transactions

- Who can conduct a Batch submission
- What kinds of transactions are available
- Where do I get information
- Contact information

HIPAA Transactions

- Who can conduct a Batch submissions

  - ✓ Anyone can as long as you or your clearinghouse have gone through testing to confirm your software is HIPAA compliant.

  - ✓ Link to HIPAA batch testing site- http://hrsa.dshs.wa.gov/providerone/HIPAAtesting.htm

HIPAA Transactions

- What kinds of transactions are available

  - ✓ All the available HIPAA transactions and their description can be found at this site: http://hrsa.dshs.wa.gov/dshshipaa/attachments/pdf/TransactionCodeDescriptions-v1_051704.pdf

HIPAA Transactions

- Where do I get information
  - ✓ http://hrsa.dshs.wa.gov/dshshipaa/

- Contact information
  - ✓ Hipaa-help@hca.wa.gov

Online Services

Provider One Stop Shopping Website

Washington State Medicaid

Providers home | Training | Fact Sheets | Links | Claims and Billing | New Provider | ProviderOne | ProviderOne Manuals

Programs and Services Directory

Client Services
Eligibility
Health Care for Children
Healthy Options
Maternity and Infants

Provider Services
Billing Instructions
Durable Medical Equipment
Hospital Payments
Professional Payments

Enrollment Reports
Forms
News
Publications
Reports

Budget
Health Care Authority
Medicaid State Plan
WACs and Proposed Changes

Medicaid Providers

News

Proposed Emergency Room changes have been suspended and did not go into effect April 1.

Medicare and Medicaid: Dual eligibles project posted.

HHS-OIG Compliance Training oig.hhs.gov

HIPAA 5010/NCPDP D.O Implemented January 1, 2012 - ProviderOne software was updated for HIPAA 5010 and NCPDP D.0. Technical specification documents are available at our HIPAA/5010 website.

New Registration and Authorization Process (See Advanced Imaging).

News Release: Three-visit limit overturned by judge (November 10, 2011)

September 22, 2011: Health Care Authority Director Doug Porter announces September budget package.

Contract All | Expand All

You may also want to visit:

Budget Cuts how they affect the Medicaid Program

ProviderOne Billing and Resource Guide an overview of Medicaid, billing, and system usage

Join the Medicaid email list for providers to get the latest information specific to your business

ProviderOne Weekly Claims Report
Providers can check their claim statistics by tax ID then NPI

Scope of Care client coverage eligibility for services

Coordination of Benefits

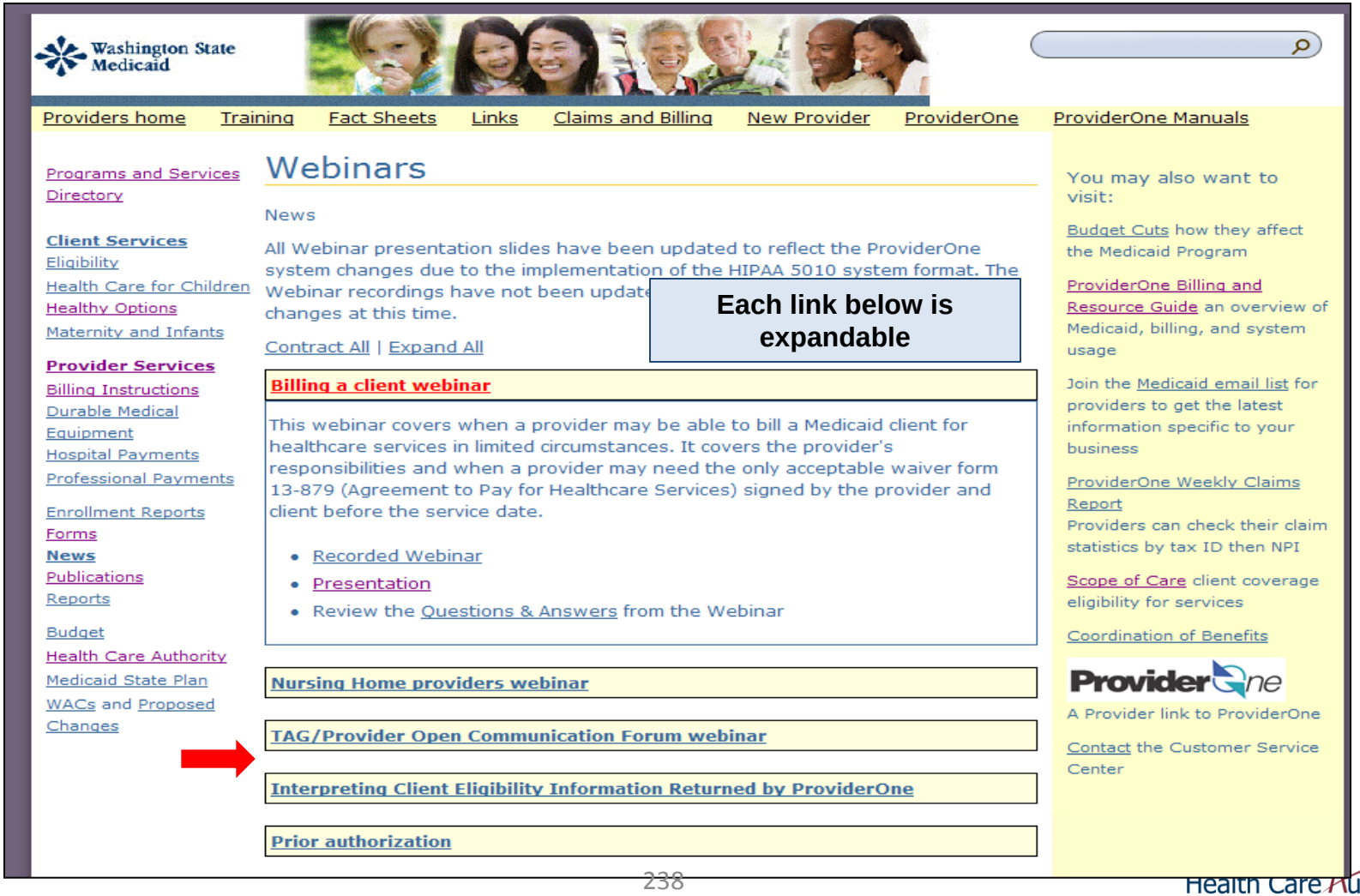
ProviderOne
A Provider link to ProviderOne

Contact the Customer Service Center

http://hrsa.dshs.wa.gov/Provider/

Training Tab

Webinars


Washington State Medicaid
Providers home
Training
Fact Sheets
Links
Claims and Billing
New Provider
ProviderOne
ProviderOne Manuals
Programs and Services Directory
Client Services
Eligibility
Health Care for Children
Healthy Options
Maternity and Infants
Provider Services
Billing Instructions
Durable Medical Equipment
Hospital Payments
Professional Payments
Enrollment Reports
Forms
News
Publications
Reports
Budget
Health Care Authority
Medicaid State Plan
WACs and Proposed Changes
Webinars
News
All Webinar presentation slides have been updated to reflect the ProviderOne system changes due to the implementation of the HIPAA 5010 system format. The Webinar recordings have not been update
changes at this time.
Each link below is expandable
Contract All | Expand All
Billing a client webinar
This webinar covers when a provider may be able to bill a Medicaid client for healthcare services in limited circumstances. It covers the provider's responsibilities and when a provider may need the only acceptable waiver form 13-879 (Agreement to Pay for Healthcare Services) signed by the provider and client before the service date.
Recorded Webinar
Presentation
Review the Questions & Answers from the Webinar
Nursing Home providers webinar
TAG/Provider Open Communication Forum webinar
Interpreting Client Eligibility Information Returned by ProviderOne
Prior authorization
You may also want to visit:
Budget Cuts how they affect the Medicaid Program
ProviderOne Billing and Resource Guide an overview of Medicaid, billing, and system usage
Join the Medicaid email list for providers to get the latest information specific to your business
ProviderOne Weekly Claims Report
Providers can check their claim statistics by tax ID then NPI
Scope of Care client coverage eligibility for services
Coordination of Benefits
ProviderOne
A Provider link to ProviderOne
Contact the Customer Service Center

Links Tab

Easy to find direct links to Medicaid Programs

Medicaid Provider Services Links

Here are some information links that may be useful to a Medicaid Provider:

- Alien Emergency Medical Program (AEM)
- Authorization Services
- Billing Instructions
- Coordination of Benefits
- Dental Services
- Department of Social and Health Services (DSHS)
- DSHS Division of Behavioral Health & Recovery (DBHR)
- Document Cover Sheets
- Drug Use Assistance
- Durable Medical Equipment
- Electronic Health Record Incentive Program
- Emergency Rooms
- Federal EOB and Taxomony Code list
- Federally Qualified Health Centers and Rural Health Clinics
- Frequently Asked Questions (FAQ)
- Health Care Programs & Services
- Healthy Options (Managed Care)
- HIPAA Home Page
- Hospital Payments
- Interpreter Services
- Kidney Disease Program
- Medicaid News
- Medicaid Rule Making Actions
- Medicaid State Plan
- Mental Health Services
- NPPES
- Numbered Memos
- Pharmacy Information Site
- Professional Services Rates
- ProviderOne Billing and Resource Guide
- Provider Enrollment
- ProviderOne Log-In
- ProviderOne System Manuals
- Patient Review & Coordination Program
- Regional Support Networks (RSN)
- Substance Abuse Help
- Swipe Card Readers
- Tribal Health
- Washington Administrative Code (WAC)

Discovery Log

ProviderOne Billing and Resource Guide

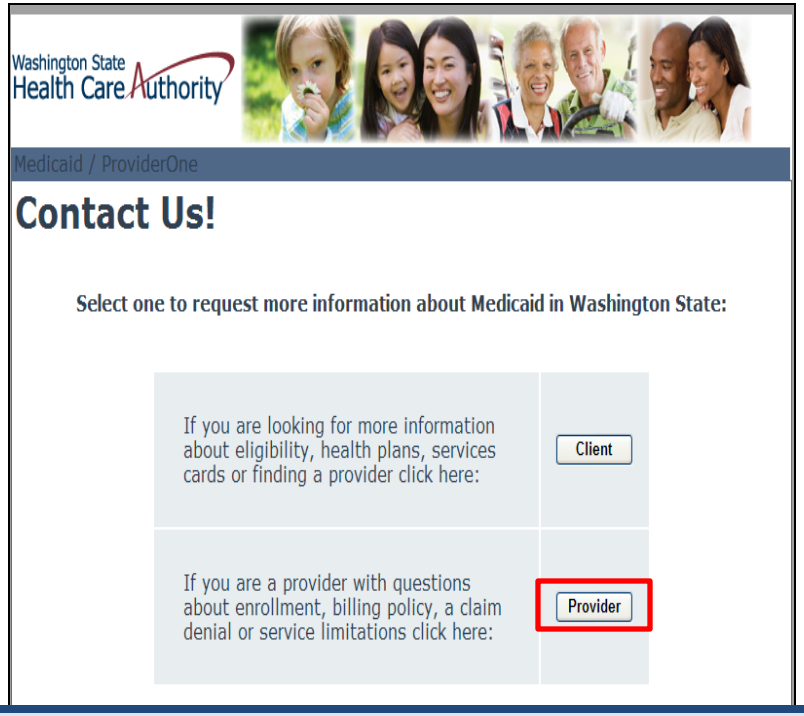
ProviderOne Billing and Resource Guide

This Guide:

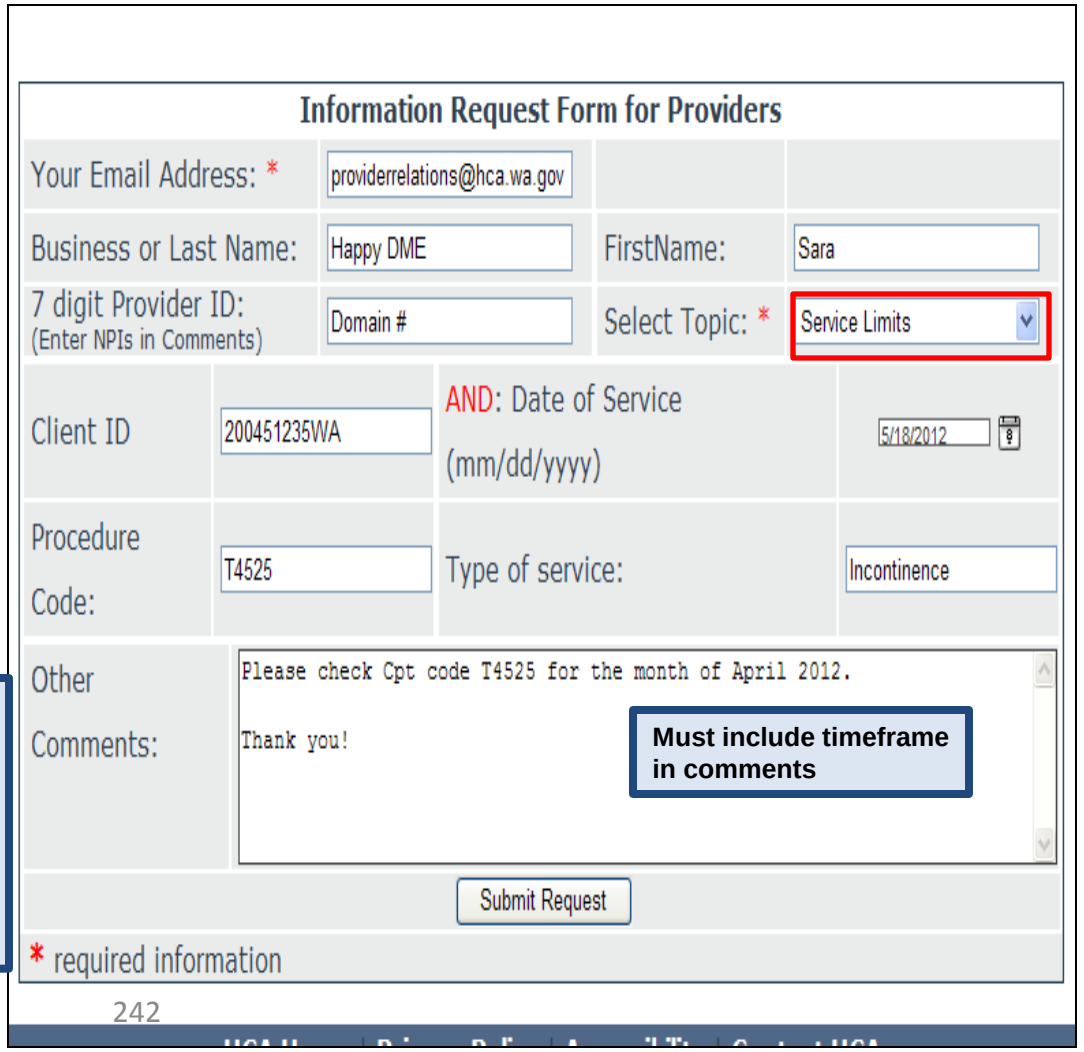
- Provides general information that applies to most Medicaid providers.
- Takes providers through the process for billing the Medicaid Program of the Health Care Authority for covered services delivered to eligible clients.

http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html

Contact Us!



- 48 hr turnaround for **Service Limits** checks
  - Be sure to include the Date of Service (DOS)
  - Procedure Code and the date range for search
  - ProviderOne Domain number



Helpful Links Related to Client Eligibility

For the following Fact Sheets, use the hyperlink listed below:

- Client Services Card Fact Sheet
- Client Eligibility Verification Fact Sheet
- Interactive Voice Response (IVR) Fact Sheet
- Magnetic Card Reader Fact Sheet

http://hrsa.dshs.wa.gov/providerone/Providers/Fact%20Sheets/FactSheets.htm

For the E-Learning Webinar on how to check eligibility in ProviderOne, use the hyperlink listed below:

http://hrsa.dshs.wa.gov/providerone/EEligibility.htm

For the Self-Paced Online Tutorial on how to check eligibility, use the hyperlink listed below:

http://hrsa.dshs.wa.gov/providerone/ProviderTutorials.htm

For the ProviderOne Billing and Resource Guide, use the hyperlink listed below:

http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html

General Information about Medicaid

- Summarized in the ProviderOne Billing and Resource Guide http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html.
- See the Provider Training web site for links to recorded Webinars, E-Learning, and Manuals http://www.dshs.wa.gov/provider/training.shtml.
- Find the Tribal Medicaid Provider Guide (formerly the billing instructions) at http://hrsa.dshs.wa.gov/Download/BI.html.

General Information about Medicaid

- Emergency Oral Health Factsheet http://hrsa.dshs.wa.gov/DentalProviders/FAX/EPA.pdf
- Provider Enrollment web page at http://hrsa.dshs.wa.gov/ProviderEnroll/enroll.shtml#provider.

Questions